MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 08843

08835 CERTIFICATE OF DEATH Reg. Dist. No. 332

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15

1. PLACE OF DEATH:
COUNTY Wicomico — STATE MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN SALISBURY — LENGTH OF STAY (in this place) 2 YRS.
HOSPITAL OR INSTITUTION OR STREET ADDRESS Pen. Gen. Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE MARYLAND — Wicomico
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN SALISBURY
STREET ADDRESS (If rural give location) CANDEN AVE., EXT.

3. NAME OF DECEASED: (Type or Print) (First) MARTHA (Middle) PERLA (Last) ALLEN
4. DATE OF DEATH: (Month) 9 (Day) 19 (Year) 1954
5. SEX: FEMALE
6. COLOR OR RACE: WHITE
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): WIDOWED
8. DATE OF BIRTH: JUNE 20, 1870
9. AGE last birthday: 84 yrs. IF UNDER 1 YEAR: Months / Days; IF UNDER 24 HRS.: Hours / Min.
10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired: HOUSE WIFE
10b. KIND OF BUSINESS OR INDUSTRY: OWN HOME
11. BIRTHPLACE (State or foreign country): MARYLAND
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: DILLIS E. TAYLOR
14. MOTHER'S MAIDEN NAME: SOPHRONIA DARBY
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) — (If Yes, give war or dates of service)
16. SOCIAL SECURITY NO.:
17. INFORMANT'S ADDRESS: W. LEE ALLEN - SALISBURY, MD.

18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — Interval Between Onset And Death

Immediate cause (a) Coronary Occlusion — 18 hrs.
420.1
DUE TO

Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last.
(b)
DUE TO
(c)

11. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: 19b. MAJOR FINDINGS OF OPERATION 20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) — PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. — INJURY OCCURED While at Work ☐ Not While At Work ☐ — HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from May, 1946, to 9/19, 1954 that I last saw the deceased alive on 9/19, 1954, and that death occurred at 7:45 am from the causes and on the date stated above.

SIGNATURE (Degree or title) Fred P. Adams M.D. — ADDRESS Salisbury Md — DATE SIGNED 9/19/54

23. BURIAL, CREMATION, REMOVAL (Specify) Burial — DATE THEREOF 9/21/54 — NAME OF CEMETERY OR CREMATORY Parsons Cemetery — LOCATION (City, town, or county) (State) Salisbury, Maryland

DATE REC'D BY LOCAL REGISTRAR 9-20-54 — REGISTRAR'S SIGNATURE Mary M. Holloway

24. FUNERAL DIRECTOR Hill & Johnson Co — ADDRESS Salisbury, Md
George C. Hill II

RECEIVED
SEP 22 1954
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 08844

08836

CERTIFICATE OF DEATH

Reg. Dist. No. 332

1. PLACE OF DEATH:
COUNTY Wicomico — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Salisbury — LENGTH OF STAY (in this place) 1Y
HOSPITAL OR INSTITUTION OR STREET ADDRESS Spring Hill - Rt. Sanitorium

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Virginia — COUNTY Accomack
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN New Church
STREET ADDRESS (If rural give location) Star Route 83x-2

3. NAME OF DECEASED: (Type or Print) (First) Hattie (Middle) H. (Last) Ardis

4. DATE OF DEATH: (Month) Sept. (Day) 21 (Year) 1954

5. SEX: Female

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Married

8. DATE OF BIRTH: June 16, 1882

9. AGE last birthday: 72 yrs. IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION. Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: Own Home

11. BIRTHPLACE (State or foreign country): Virginia

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: C.J. Silver Thorne

14. MOTHER'S MAIDEN NAME: Sarah Taylor

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No — (If Yes, give war or dates of service) None

16. SOCIAL SECURITY NO.: None

17. INFORMANT & ADDRESS: Harry W. Ardis, New Church, Va

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

4427

Immediate cause (a) Cardio vascular renal disease — Interval Between Onset And Death

DUE TO

Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last.

(b)

DUE TO

(c)

11. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: — 19b. MAJOR FINDINGS OF OPERATION — 20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) — PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) — (CITY OR TOWN) — (COUNTY) — (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. — INJURY OCCURED While at Work ☐ Not While At Work ☐ — HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 12/6, 1953, to 9/21, 1954, that I last saw the deceased alive on 9/21, 1954, and that death occurred at 11:35 A.M., from the causes and on the date stated above.

SIGNATURE (Degree or title) Philip A Insley M.D. — ADDRESS Salisbury Md — DATE SIGNED 9-22-54

23. BURIAL, CREMATION, REMOVAL (Specify) Burial — DATE THEREOF 9-26-54 — NAME OF CEMETERY OR CREMATORY Nelson Cemetery — LOCATION (City, town, or county) (State) Pocomoke, Md

DATE REC'D BY LOCAL REGISTRAR 9-27-54 — REGISTRAR'S SIGNATURE Mary W. Holloway

24. FUNERAL DIRECTOR Henry H. Watson — ADDRESS Pocomoke, Md.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
SEP 27 1954
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 08845

CERTIFICATE OF DEATH

Reg. Dist. No. 332

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15 8-51

1. PLACE OF DEATH:

COUNTY Wicomico — MARYLAND

CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Salisbury, Md. — LENGTH OF STAY (in this place) 10½ mos.

HOSPITAL OR INSTITUTION OR STREET ADDRESS Beer's Head State

2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE Maryland COUNTY Caroline

CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Greensboro

STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED: (Type or Print) (First)	(Middle)	(Last)	4. DATE OF DEATH: (Month)	(Day)	(Year)
Clarence	Isaac	Barcus	9	3	19 54

5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH:	9. AGE last birthday:	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
M	W	Wid.	June 20, 1874	80 yrs.				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):	10b. KIND OF BUSINESS OR INDUSTRY:	11. BIRTHPLACE (State or foreign country):	12. CITIZEN OF WHAT COUNTRY?
Painter		Delaware	

13. FATHER'S NAME:	14. MOTHER'S MAIDEN NAME:
John W. Barcus	Mary Hutson

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.)	(If Yes, give war or dates of service)	16. SOCIAL SECURITY NO.:	17. INFORMANT & ADDRESS:
Unk.	Unk	******	Hospital Records

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

		INTERVAL BETWEEN ONSET AND DEATH
420.1 Immediate cause	(a) Coronary thrombosis	1 hr.
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating underlying cause last	DUE TO (b) Arteriosclerosis general	?
	DUE TO (c)	

II. OTHER SIGNIFICANT CONDITIONS: Conditions contributing to the death but not related to the disease or condition causing death. Fibrosis pulmonary right — ?

19a. DATE OF OPERATION:	19b. MAJOR FINDINGS OF OPERATION:	20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)	PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)

TIME OF INJURY (Month)	(Day)	(Year)	(Hour)	INJURY OCCURRED While at work ☐ Not while at work ☐	HOW DID INJURY OCCUR?
			M.		

22. I hereby certify that I attended the deceased from 10/27, 1953, to 9/3, 1954, that I last saw the deceased alive on 9/3, 1954, and that death occurred at 5 PM m., from the causes and on the date stated above.

SIGNATURE	(DEGREE OR TITLE)	ADDRESS	DATE SIGNED
Dr V Sherman	M.D.	Deers Head Hospital, Salisbury	9/3/54.

23. BURIAL, CREMATION, REMOVAL (Specify):	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Removal	Sept 7 1954	Loudon Memorial Pk	Balto - Md

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
9-7-54	Mary W. Holloway	Booker M Coates	

RECEIVED
SEP 9 1954
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08837 08846

CERTIFICATE OF DEATH

Reg. Dist. No. 332

M

I

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH:
COUNTY Wicomico MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Salisbury
LENGTH OF STAY (in this place) 20 Mons
HOSPITAL OR INSTITUTION OR STREET ADDRESS Spring Hill Pr. Sanatarium

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland COUNTY Wicomico
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Salisbury
STREET ADDRESS (If rural give location) 110 William St.

3. NAME OF DECEASED: (Type or Print) (First) Bessie (Middle) Truitt (Last) Bounds

4. DATE OF DEATH: (Month) 9 (Day) 29 (Year) 1954

5. SEX: Female
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Widowed
8. DATE OF BIRTH: Oct. 8, 1879
9. AGE last birthday: 75 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION. Give kind of work done during most of working life, even if retired: House Wife
10b. KIND OF BUSINESS OR INDUSTRY: Own Home
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY: U.S.A.

13. FATHER'S NAME: Zedekiak Truitt
14. MOTHER'S MAIDEN NAME: Gertrude Laws.

15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No (If Yes, give war or dates of service) —
16. SOCIAL SECURITY No.: None
17. INFORMANT & ADDRESS: Mrs Louise B. Stewart, Salisbury

18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Interval Between Onset And Death

442X

Immediate cause (a) Cardiovascular rural disease

DUE TO

Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. (b)

DUE TO

(c)

11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE (Specify)
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURED While at Work ☐ Not While At Work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from ....., 1952 to 9-29, 1954, that I last saw the deceased alive on 9-29, 1954, and that death occurred at 7:40 PM, from the causes and on the date stated above.

SIGNATURE (Degree or title) Philip A. Lusby Med
ADDRESS Salisbury Md
DATE SIGNED 10-1-54

23. BURIAL, CREMATION, REMOVAL (Specify) Burial
DATE THEREOF 10/1/54
NAME OF CEMETERY OR CREMATORY Parsons Cemetery
LOCATION (City, town, or county) (State) Salisbury, Md

DATE REC'D BY LOCAL REGISTRAR 10-1-54
REGISTRAR'S SIGNATURE Mary W. Holloway
24. FUNERAL DIRECTOR The Hill & Johnson Co. ADDRESS Salisbury, Md.
George C Hill II

RECEIVED
OCT 4 1954
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 08847

08877 CERTIFICATE OF DEATH

Reg. Dist. No. 332

Dr. Lewis

1. PLACE OF DEATH:
COUNTY Wicomico MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Salisbury
LENGTH OF STAY (in this place) X
HOSPITAL OR INSTITUTION OR STREET ADDRESS R.D. # 5

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland COUNTY Wicomico
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Salisbury 12
STREET ADDRESS (If rural give location) Holland Ave. & E. Isabella St;

3. NAME OF DECEASED: (Type or Print)	(First)	(Middle)	(Last)	4. DATE OF DEATH: (Month)	(Day)	(Year)
	CORA	JANE	BUTLER	SEPT	29	19 54

5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH:	9. AGE last birthday:	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Female	White	Widowed	Sept. 6, 1884	70 yrs.	0	23		

10a. USUAL OCCUPATION. Give kind of work done during most of working life, even if retired):	10b. KIND OF BUSINESS OR INDUSTRY:	11. BIRTHPLACE (State or foreign country):	12. CITIZEN OF WHAT COUNTRY?
House Work	At own Home	Reeds Grove, Maryland	USA

13. FATHER'S NAME:	14. MOTHER'S MAIDEN NAME:
James Bramble	Sarah Medford

15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)	16. SOCIAL SECURITY NO.:	17. INFORMANT & ADDRESS:
No		Mrs. Irene Parker (Daughter) R.D. # 5

18. MEDICAL CERTIFICATION Salisbury, Maryland

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		Interval Between Onset And Death
Immediate cause 443X	(a) Myocarditis Chronic	2 years
Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last.	(b) Arteriosclerosis-hypertension DUE TO	
	(c) DUE TO	

11. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
—	—	Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	(CITY OR TOWN)	(COUNTY)	(STATE)
—	—	—	—	—

TIME OF INJURY (Month)	(Day)	(Year)	(Hour)	INJURY OCCURED While at Work ☐ Not While At Work ☐	HOW DID INJURY OCCUR?
—			m.		—

22. I hereby certify that I attended the deceased from ....., 19 57, to 9-21, 19 54, that I last saw the deceased alive on 9-21, 19 54, and that death occurred at 7:30 A.M., from the causes and on the date stated above.

SIGNATURE Frank K. Lewis (Degree or title) M.D. ADDRESS Willards, Maryland DATE SIGNED Sept. 30 1954

23. BURIAL, CREMATION, REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	Oct. 1, 1954	Wicomico Memorial Park	Salisbury, Maryland

DATE REC'D BY LOCAL REGISTRAR 9 30 54 REGISTRAR'S SIGNATURE Mary M. Holloway

24. FUNERAL DIRECTOR HOLLOWAY & COMPANY ADDRESS SALISBURY MARYLAND

Walter R. Holloway Walter R. Holloway

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
OCT 4 1954
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 08848

08838

CERTIFICATE OF DEATH

Item 7, Film 171 10-6-54 et

Reg. Dist. No. 327

1. PLACE OF DEATH:
COUNTY Wicomico — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Salisbury
LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS Peninsula General Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland COUNTY Wicomico
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Fruitland
STREET ADDRESS (If rural give location)

3. NAME OF DECEASED: (Type or Print) (First) Sarah (Middle) (Last) Common

4. DATE OF DEATH: (Month) September (Day) 30 (Year) 1954

5. SEX: Female

6. COLOR OR RACE: C

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Married

8. DATE OF BIRTH: mar 7 1905

9. AGE last birthday: 49 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired):

10b. KIND OF BUSINESS OR INDUSTRY: Dress Poultry

11. BIRTHPLACE (State or foreign country): westover somerset co md

12. CITIZEN OF WHAT COUNTRY? U S A

13. FATHER'S NAME: Daniel Ballard

14. MOTHER'S MAIDEN NAME: Sarah Payton

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)

16. SOCIAL SECURITY No.:

17. INFORMANT'S ADDRESS: Ollie Burns Fruitland Md

18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause — (a) Hemorrhage Cerebral Basilar Brain — Interval Between Onset And Death: 4 days

Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. — DUE TO (b) [redacted] — DUE TO (c) [redacted]

11. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: 19b. MAJOR FINDINGS OF OPERATION 20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐ (Specify) PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. INJURY OCCURED While at Work ☐ Not While At Work ☐ HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 9/27/54, to 9/30/54, 1954, that I last saw the deceased alive on 9/30/54, 19.... ., and that death occurred at 5:35 p.m., from the causes and on the date stated above.

SIGNATURE (Degree or title) Carrie L. Keasy MD — ADDRESS 113 W Church St — DATE SIGNED 10/1/54

23. BURIAL, CREMATION, REMOVAL (Specify) Burial — DATE THEREOF oct 3-1954 — NAME OF CEMETERY OR CREMATORY St Mary — LOCATION (City, town, or county) (State) west post office Md

DATE REC'D BY LOCAL REGISTRAR 10-4-54 — REGISTRAR'S SIGNATURE Mary M Holloway

24. FUNERAL DIRECTOR Charles A Ward — ADDRESS Marion St. Md

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 08849

Dr. Mitchell 08839

CERTIFICATE OF DEATH

Reg. Dist. No. 332

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH:
COUNTY: Wicomico — MARYLAND
CITY (If outside corporate limits, write RURAL OR TOWN and give nearest town): Salisbury
LENGTH OF STAY (in this place): 1-2
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Pen. Gen. Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE: Maryland — COUNTY: Wicomico
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Fruitland
STREET ADDRESS (If rural give location): R.D. #

3. NAME OF DECEASED: (Type or Print) (First) MAMIE (Middle) MAY (Last) CAREY

4. DATE OF DEATH: (Month) SEPT (Day) 30 (Year) 19 54

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR: Months	Days	IF UNDER 24 HRS.: Hours	Min.
Female	White	Widowed	Sept. 13, 1888	66 yrs.	0	17		

10a. USUAL OCCUPATION. Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
House Work	At Own Home	Shad Point, Md.	USA

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Fred A. Williams	Ida Thomas

15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)	16. SOCIAL SECURITY No.	17. INFORMANT & ADDRESS
No		Mr. William M. Carey (Son) Fruitland, Maryland

18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — Interval Between Onset And Death

410 X

Immediate cause (a) Congestive failure

DUE TO

Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last.

(b) Rheumatic heart disease - Subacute Bacterial

DUE TO

(c) Endocarditis, aortic Stenosis, mitral Stenosis.

11. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		Yes ☒ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)	PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	(CITY OR TOWN)	(COUNTY)	(STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour)	INJURY OCCURED While at Work ☐ Not While At Work ☐	HOW DID INJURY OCCUR?
m.		

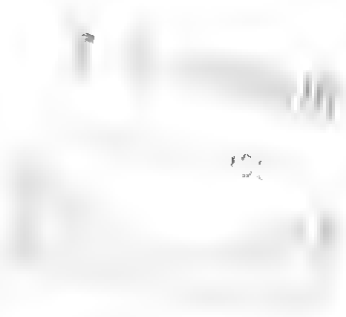
22. I hereby certify that I attended the deceased from ..., 19..., to 9/30, 1954, that I last saw the deceased alive on ..., 19..., and that death occurred at 8:25 P.M., from the causes and on the date stated above.

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
A. C. Mitchell	M.D.	N. Division St. Salisbury, Maryland	Oct. 1954

23. BURIAL, CREMATION, REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	Oct. 3, 1954	Fruitland Cemetery	Fruitland Maryland

DATE REC'D BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
10-5-54	Maryell Holloway	HOLLOWAY & COMPANY	SALISBURY MARYLAND

Walter R. Holloway



08878 08850

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Reg. Dist.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

No. 336

1. PLACE OF DEATH:
COUNTY Wicomico MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Quantico
LENGTH OF STAY (in this place) 1 yr
HOSPITAL OR INSTITUTION OR STREET ADDRESS P.O.Box 25

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland COUNTY Wicomico
CITY (If outside corporate limits write RURAL and give nearest town) OR TOWN Quantico
STREET ADDRESS (If rural, give location) Rural

3. NAME OF DECEASED: (Type or Print) (First) Fred (Middle) Paynter (Last) Carmine
4. DATE OF DEATH (Month) Sept. (Day) 5 (Year) 1954
5. SEX: Male
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Single
8. DATE OF BIRTH: 5-10-1909
9. AGE last birthday: 45 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): Painter
10b. KIND OF BUSINESS OR INDUSTRY: Painter
11. BIRTHPLACE (State or foreign country): Millsboro, Del
12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME: Roland G.Carmine
14. MOTHER'S MAIDEN NAME: Emma J.Rodgers
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) Yes (If Yes, give war or dates of service) W W # 2
16. SOCIAL SECURITY No.: 222-05-8821
17. INFORMANT & ADDRESS: Lorenzo Carmine, Quantico, Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH: — INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Shotgun wounds of Brain
DUE TO

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating underlying cause last (b)
DUE TO
(c)

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

19a. DATE OF OPERATION:
19b. MAJOR FINDING OF OPERATION:
20. AUTOPSY? Yes ☑ No ☐
21a. EXTERNAL CAUSE WAS PRIMARY ☑ or CONTRIBUTING ☐ CAUSE OF DEATH.
21b. PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY Home
21c. (City or town) Quantico (County) Wicomico (State) Md.
21d. TIME OF INJURY (Month) Sept (Day) 5 (Year) 1954 (Hour) 12:30 P.M.
21e. INJURY OCCURRED While at work ☐ Not while at work ☑
21f. HOW DID INJURY OCCUR? Shot with Shotgun.

22. I hereby certify that I took charge of the remains described above, held an Autopsy ☑, Inspection ☑, Inquiry ☑, and find that death resulted from: Natural causes ☐, Accident ☐, Suicide ☐, Homicide ☑, Undetermined cause ☐.

SIGNATURE Emil L. Rodgers M. D.
CHIEF MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAM. ☑
DATE SIGNED 9-7-54

23. BURIAL, CREMATION, REMOVAL (Specify): Burial
DATE THEREOF 9-8-54
NAME OF CEMETERY OR CREMATORY Mechanics
LOCATION (City, town, or county) (State) Millsboro, Del.
DATE REC'D BY LOCAL REG. September 7, 1954
REGISTRAR'S SIGNATURE Harry E. Hudson Sr.
24. FUNERAL DIRECTOR W. S. Mamel Co. ADDRESS Delmar, Del.

M

I

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15A-5-53

RECEIVED
SEP
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 08851

08879

CERTIFICATE OF DEATH

Reg. Dist. No. 336

1. PLACE OF DEATH: COUNTY Wicomico MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Delmar
LENGTH OF STAY (in this place) 56 yrs
HOSPITAL OR INSTITUTION OR STREET ADDRESS 4 W.State St.

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Wicomico
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Delmar
STREET ADDRESS (If rural give location) 4 W.State St.

3. NAME OF DECEASED: (Type or Print) (First) Helen (Middle) Mitchell (Last) Collins
4. DATE OF DEATH: (Month) Sept. (Day) 5 (Year) 1954
5. SEX: Female
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married
8. DATE OF BIRTH: 9-6-1897
9. AGE last birthday: 56 yrs. IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS.: Hours Min.

10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired): At Home
10b. KIND OF BUSINESS OR INDUSTRY: Home
11. BIRTHPLACE (State or foreign country): Ocean City, Md.
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Charles Mitchell
14. MOTHER'S MAIDEN NAME: Mary Adkins

15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No (If Yes, give war or dates of service)
16. SOCIAL SECURITY No.: ----
17. INFORMANT & ADDRESS: Rueben Collins, Delmar, Del.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Carcinoma of cervix with metastases + local extension to pelvis. — Interval Between Onset And Death: 1½ years

DUE TO

Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. (b)

DUE TO

(c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☑

21. ACCIDENT SUICIDE HOMICIDE (Specify)
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURED While at Work ☐ Not While At Work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 4/1, 1953, to death, 19.., that I last saw the deceased alive on 9/4, 1954, and that death occurred at 7:30 PM, from the causes and on the date stated above.

SIGNATURE Ernest M. Larmore (Degree or title) M.D. ADDRESS Delmar, Del DATE SIGNED 9/6/54

23. BURIAL, CREMATION, REMOVAL (Specify) Burial
DATE THEREOF 9-9-54
NAME OF CEMETERY ~~OR CREMATORY~~ Mt Olive
LOCATION (City, town, or county) (State) Delmar, Del.

DATE REC'D BY LOCAL REGISTRAR September 7, 1954
REGISTRAR'S SIGNATURE Harry E. Hudson Sr.
24. FUNERAL DIRECTOR W. S. Mann Co ADDRESS Delmar, Del

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

SEP 9 1954
BUREAU V. E.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08840

CERTIFICATE OF DEATH

08852

Reg. Dist. No. 332

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians; please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
COUNTY Wicomico — STATE MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Salisbury Rt 2 — LENGTH OF STAY (in this place) 11 days
HOSPITAL OR INSTITUTION OR STREET ADDRESS Peninsula General Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland — COUNTY Wicomico
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Salisbury Rt 4
STREET ADDRESS (If rural give location) Parkway

3. NAME OF DECEASED: (Type or Print) (First) CHARLES (Middle) a (Last) CONWAY

4. DATE OF DEATH: (Month) Sept. (Day) 23 (Year) 1954

5. SEX: MALE

6. COLOR OR RACE: WHITE

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): MARRIED.

8. DATE OF BIRTH: Jan. 23, 1903

9. AGE last birthday: 51 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired: Construction Laborer

10b. KIND OF BUSINESS OR INDUSTRY: Day & Co. Cons

11. BIRTHPLACE (State or foreign country): Millford Del.

12. CITIZEN OF WHAT COUNTRY? U.S.A

13. FATHER'S NAME: William B. Conaway

14. MOTHER'S MAIDEN NAME: Sallie Hall

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) Unknown

16. SOCIAL SECURITY No.: 221-18-0728

17. INFORMANT & ADDRESS: Addie Conaway, Salisbury Md

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — Interval Between Onset And Death

Immediate cause (a) Congestive Heart Failure & Uraemia.

Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last.
DUE TO (b) Chronic Interstitial Nephritis
DUE TO (c) arteriosclerosis

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: — **19b. MAJOR FINDINGS OF OPERATION** — **20. AUTOPSY?** Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) — PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) — (CITY OR TOWN) — (COUNTY) — (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. — INJURY OCCURED While at Work ☐ Not While At Work ☐ — HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 9-13 ..., 1954, to 9/22/54., 19 ..., that I last saw the deceased alive on 9/22/54 19....., and that death occurred at 5:07 A.M., from the causes and on the date stated above.

SIGNATURE (Degree or title) Carrie J. Hearn MD — ADDRESS 1365 Church St — DATE SIGNED 9/23/54

23. BURIAL, CREMATION, REMOVAL (Specify) — DATE THEREOF 9-26-54 — NAME OF CEMETERY OR CREMATORY Oddfellows Cemetery — LOCATION (City, town, or county) (State) Seaford, Del.

DATE REC'D BY LOCAL REGISTRAR 9-24-54 — REGISTRAR'S SIGNATURE Mary M. Holloway

24. FUNERAL DIRECTOR W. S. Manuel Co. — ADDRESS Delmar Del.

VS. A15

Lambdin

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08853

08841

CERTIFICATE OF DEATH

Reg. Dist. No. 332

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15 8-54

1. PLACE OF DEATH:
COUNTY Wicomico — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Salisbury
LENGTH OF STAY (in this place) 2 days
HOSPITAL OR INSTITUTION OR STREET ADDRESS Peninsula General Hosp.

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland — COUNTY Wicomico
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Willards
STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED: (Type or Print) Baby Girl (First) Marie (Middle) Cooper (Last)

4. DATE OF DEATH: (Month) 9 (Day) 21 (Year) 1954

5. SEX: F

6. COLOR OR RACE: W

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):

8. DATE OF BIRTH: 9-19-54

9. AGE last birthday: yrs. — IF UNDER 1 YEAR: Months, Days 2 — IF UNDER 24 HRS.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Norman Joseph Cooper

14. MOTHER'S MAIDEN NAME: Louise Virginia Smith

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)

16. SOCIAL SECURITY NO.:

17. INFORMANT & ADDRESS: Norman J. Cooper, Willards, Md

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

Immediate cause (a) Prematurity

DUE TO

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating underlying cause last

(b)

DUE TO

(c)

INTERVAL BETWEEN ONSET AND DEATH

II. OTHER SIGNIFICANT CONDITIONS: Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) — PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) — (CITY OR TOWN) — (COUNTY) — (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) M. — INJURY OCCURRED While at work ☐ Not while at work ☐ — HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 9-19, 1954, to 9-20, 1954, that I last saw the deceased alive on 9-20, 1954, and that death occurred at 12:45 a.m., from the causes and on the date stated above.

SIGNATURE (DEGREE OR TITLE) ADDRESS — DATE SIGNED

Morris A. Lambdin MD Salisbury Md 9-21-54

23. BURIAL, CREMATION, REMOVAL (Specify): 9-21-54 — NAME OF CEMETERY OR CREMATORY: Cooper Burying Plot — LOCATION (City, town, or county) (State): Willards, Md

DATE REC'D BY LOCAL REG. 9-21-54 — REGISTRAR'S SIGNATURE: Mary M. Holloway

24. FUNERAL DIRECTOR — ADDRESS: Norman J. Cooper

RECEIVED
SEP
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

08880

08854

Reg. Dist. No. 382

PLEASE WRITE PLAINLY WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15

1. PLACE OF DEATH:
COUNTY: Wicomico — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Salisbury, Rt. # 1
LENGTH OF STAY (in this place): Most of life
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Salisbury, Route # 1

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE: Maryland — COUNTY: Wicomico
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Near Salisbury
STREET ADDRESS (If rural give location): Route # 1

3. NAME OF DECEASED: (First) Addie (Middle) Emily (Last) Cottman

4. DATE OF DEATH: (Month) 9 (Day) 30 (Year) 1954

5. SEX: Female

6. COLOR OR RACE: A.A.

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Widow

8. DATE OF BIRTH: 10-5-1878

9. AGE last birthday: 75 yrs. IF UNDER 1 YEAR: Months 11 Days 25 IF UNDER 24 HRS.: Hours Min.

10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: At home

11. BIRTHPLACE (State or foreign country): Dames Quarter, Somerset Co. Md.

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Joshua Wilson

14. MOTHER'S MAIDEN NAME: Martha Wilson

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.): No
(If Yes, give war or dates of service): No

16. SOCIAL SECURITY No.: None

17. INFORMANT & ADDRESS: Miss Ernestine Cottman, 2439 N. College Ave. Phila. Pa.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause — (a) Carcinoma of Liver — Interval Between Onset And Death: 2 wks.

DUE TO

Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last.

(b)

DUE TO

(c)

196.1

11. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURED While at Work ☐ Not While At Work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 9-23, 1954, to 9-30, 1954, that I last saw the deceased alive on 9-30-54, 19....., and that death occurred at 6 P.M. ....., from the causes and on the date stated above.

SIGNATURE (Degree or title): Lee L Lawry M.D. — ADDRESS: Fruitland Md — DATE SIGNED: 10-1-54

23. BURIAL, CREMATION, REMOVAL, (Specify): Burial

DATE THEREOF: 10-3-'54

NAME OF CEMETERY OR CREMATORY: Mt. Olive Cemetery

LOCATION (City, town, or county) (State): Fruitland, Wicomico Co. Md.

DATE REC'D BY LOCAL REGISTRAR: 10-4-54

REGISTRAR'S SIGNATURE: Mary W. Holloway

24. FUNERAL DIRECTOR: Mary A Stewart, 324 E Church St. Salisbury, Md.

STEWART FUNERAL HOME

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08855

08842

CERTIFICATE OF DEATH

Reg. Dist. No. 332

1. PLACE OF DEATH: COUNTY Wicomico MARYLAND	2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Wicomico
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury — LENGTH OF STAY (in this place) 6 hrs.	CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Delmar
HOSPITAL OR INSTITUTION OR STREET ADDRESS Peninsula Gen. Hosp.	STREET ADDRESS (If rural give location) 414 Pine Street

3. NAME OF DECEASED: (Type or Print) (First) Louotta (Middle) Gordy (Last) Culver

4. DATE OF DEATH: (Month) Sept. (Day) 12 (Year) 1954

5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH:	9. AGE last birthday:	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Male	White	Widowed	July 24, 1889	65 yrs.				

10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY:	11. BIRTHPLACE (State or foreign country):	12. CITIZEN OF WHAT COUNTRY?
Electrician	Railroad	Wicomico County, Md	USA

13. FATHER'S NAME:	14. MOTHER'S MAIDEN NAME:
Winder Culver	Martha W.Gillis

15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.)	(If Yes, give war or dates of service)	16. SOCIAL SECURITY No.:	17. INFORMANT & ADDRESS:
No	-----	218-20-4783	Martha Perry, Delmar, Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		Interval Between Onset And Death
420.1 Immediate cause	(a) Myocardial Infarct, acute	8 hrs.
Antecedent causes(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last.	DUE TO (b) Arteriosclerotic coronary thrombosis	"
	DUE TO (c)	

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: 19b. MAJOR FINDINGS OF OPERATION 20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE (Specify) PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. INJURY OCCURED While at Work ☐ Not While At Work ☐ HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 9-12, 1954, to 9-12, 1954, that I last saw the deceased alive on 9-12, 1954, and that death occurred at 1:30 P.M. from the causes and on the date stated above.

SIGNATURE (Degree or title)	ADDRESS	DATE SIGNED
Wilbur R. Ellis, Jr. MD	Salisbury, Md.	9-12-54

23. BURIAL, CREMATION, REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	9-15-54	Mt Olive Methodist	Delmar, Del.

DATE REC'D BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
9-14-54	Mary W. Holloway	H. S. Mann Co.	Delmar, Del

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
SEP 16 1954
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 08856

08881

CERTIFICATE OF DEATH

Reg. Dist. No. 332

1. PLACE OF DEATH:
COUNTY Wicomico MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Tyaskin
LENGTH OF STAY (in this place) Lifetime
HOSPITAL OR INSTITUTION OR STREET ADDRESS

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland COUNTY Wicomico
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Tyaskin
STREET ADDRESS (If rural give location) R.F.D.

3. NAME OF DECEASED: (Type or Print) (First) Joseph (Middle) W. (Last) Dashield
4. DATE OF DEATH: (Month) 9 (Day) 23 (Year) 1954
5. SEX: M
6. COLOR OR RACE: C
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Widowed
8. DATE OF BIRTH: 4/25/1864
9. AGE last birthday: 90 yrs. IF UNDER 1 YEAR Months 4 Days 28 IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired): Farmer
10b. KIND OF BUSINESS OR INDUSTRY: Own Farm
11. BIRTHPLACE (State or foreign country): Tyaskin, Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.
13. FATHER'S NAME: Robert Dashield
14. MOTHER'S MAIDEN NAME: Sarah Waters
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No (If Yes, give war or dates of service) —
16. SOCIAL SECURITY NO.: →
17. INFORMANT & ADDRESS: Lelia Hughes, Tyaskin, Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Intestinal Obstruction — Interval Between Onset And Death: 3 weeks.

Antecedent causes(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last.

DUE TO (b) Carcinoma Large Bowel — 1 year.

DUE TO (c)

11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Inanition — 1 week.

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify)
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURED While at Work ☐ Not While At Work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 8/30, 1954, to 9/23, 1954, that I last saw the deceased alive on 9/23, 1954, and that death occurred at 11:10 P.M., from the causes and on the date stated above.

SIGNATURE (Degree or title) Richard H. Saunders M.D.
ADDRESS Pantcoke Md.
DATE SIGNED 9/24/54

23. BURIAL, CREMATION, REMOVAL (Specify) Burial
DATE THEREOF 9/27/54
NAME OF CEMETERY OR CREMATORY New Town Cemetery
LOCATION (City, town, or county) (State) Tyaskin, Maryland
DATE REC'D BY LOCAL REGISTRAR 9-27-54
REGISTRAR'S SIGNATURE Mary W Holloway
24. FUNERAL DIRECTOR Cornelius G. Messick
ADDRESS Bivalve, Maryland

M

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MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
SEP 23 1954
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08857

CERTIFICATE OF DEATH

08843

Reg. Dist. No. 332

1. PLACE OF DEATH: COUNTY Wicomico MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Salisbury
LENGTH OF STAY (in this place) 2 Wks.
HOSPITAL OR INSTITUTION OR STREET ADDRESS Peninsula Gen. Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Wicomico
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Bivalve
STREET ADDRESS (If rural give location)

3. NAME OF DECEASED: (Type or Print) (First) Etha (Middle) Etta (Last) Dayton

4. DATE OF DEATH: (Month) Sept. (Day) 14 (Year) 1954

5. SEX: F
6. COLOR OR RACE: W
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Married
8. DATE OF BIRTH: 19 June 1890
9. AGE last birthday: 64 yrs. IF UNDER 1 YEAR: Months 2 Days 25 IF UNDER 24 HRS.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House Wife
10b. KIND OF BUSINESS OR INDUSTRY: Own Home
11. BIRTHPLACE (State or foreign country): Bivalve, Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: Cornelius G. Messick
14. MOTHER'S MAIDEN NAME: Hattie Larmore

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No (If Yes, give war or dates of service) —
16. SOCIAL SECURITY No.: —
17. INFORMANT & ADDRESS: Brady J. Dayton, Bivalve, Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Coronary Occlusion — Interval Between Onset And Death: 10 days

DUE TO

Antecedent causes(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. (b)

DUE TO

(c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify)
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURED While at Work ☐ Not While At Work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 9/4, 1954, to 9/14, 1974 that I last saw the deceased alive on 9/14, 1954, and that death occurred at 6 am from the causes and on the date stated above.

SIGNATURE Fred P. Gramse (Degree or title) M.D. ADDRESS Salisbury Md DATE SIGNED 9/14/54

23. BURIAL, CREMATION, REMOVAL (Specify) Burial
DATE THEREOF 9/16/54
NAME OF CEMETERY OR CREMATORY Bivalve Cem.
LOCATION (City, town, or county) (State) Bivalve, Maryland

DATE REC'D BY LOCAL REGISTRAR 9-14-54
REGISTRAR'S SIGNATURE Mary W. Holloway
24. FUNERAL DIRECTOR Cornelius G. Messick ADDRESS Bivalve, Maryland

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
SEP 16
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 08858

08844

CERTIFICATE OF DEATH

Reg. Dist. No. 332

Item 9 Fil-G172 10-27-54 et

1. PLACE OF DEATH:
COUNTY Wicomico MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Salisbury IV
LENGTH OF STAY (in this place) D.O.A.
HOSPITAL OR INSTITUTION OR STREET ADDRESS D.O.A. Peninsula General Hosp

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE N.J. COUNTY Camden
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Merchantville Six
STREET ADDRESS (If rural, give location) 7137 Park Ave

3. NAME OF DECEASED: (Type or Print) (First) Joseph (Middle) (Last) Deuber

4. DATE OF DEATH: (Month) 9 (Day) 22 (Year) 1954

5. SEX: M
6. COLOR OR RACE: W
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Married
8. DATE OF BIRTH: Oct. 29, 1902
9. AGE last birthday: 51 5/24 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): retired
10b. KIND OF BUSINESS OR INDUSTRY: Naval Clerk
11. BIRTHPLACE (State or foreign country): Pennsylvania
12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: Frederick Deuber
14. MOTHER'S MAIDEN NAME: Arletta Algood

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No (If Yes, give war or dates of service) —
16. SOCIAL SECURITY No.: None
17. INFORMANT & ADDRESS: Mrs Joseph Deuber - wife 7137 Park Ave, Merchantville, N.J.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

Immediate cause (a) Coronary occlusion — INTERVAL BETWEEN ONSET AND DEATH: 1 hour

DUE TO

Antecedent cause(s) (b)

Diseases or conditions, if any, giving rise to the above cause stating underlying cause last

DUE TO

(c)

II. OTHER SIGNIFICANT CONDITIONS: Conditions contributing to the death but not related to the disease or condition causing death. Mitral stenosis c̄ auricular fibrillation — 4 years ±

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify)
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) M.
INJURY OCCURRED While at work ☐ Not while at work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 9-21, 1954, to 9-21, 1954, that I last saw the deceased alive on 9-21, 1954, and that death occurred at 12 15 a.m., from the causes and on the date stated above.

SIGNATURE [signature] (DEGREE OR TITLE) M.D. ADDRESS Crean City, Md. DATE SIGNED 9-24-54 NEW JERSEY

23. BURIAL, CREMATION REMOVAL (Specify): Burial
DATE THEREOF 9/25/54
NAME OF CEMETERY OR CREMATORY Colestown Cemetery
LOCATION (City, town, or county) Merchantville, N.J. (State)

DATE REC'D BY LOCAL REG. 9-24-54
REGISTRAR'S SIGNATURE Mary W. Holloway
24. FUNERAL DIRECTOR Mill & Johnson Co. Salisbury Md. ADDRESS George C Mill III

VS. A15 8-51

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

SEP 7 1954
BUREAU V. S.

Dr. Grey

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 08859

08845 CERTIFICATE OF DEATH Reg. Dist. No. 332

Dr. Grey

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

I

VS. A15

1. PLACE OF DEATH:
COUNTY Wicomico MARYLAND
CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN Salisbury
LENGTH OF STAY (in this place) 3 Days
HOSPITAL OR INSTITUTION OR STREET ADDRESS Peninsula General Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland COUNTY Wicomico
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Salisbury
STREET ADDRESS (If rural give location) 309 Gay Street

3. NAME OF DECEASED: (Type or Print) (First) Sallie (Middle) Mary (Last) Disharoon

4. DATE OF DEATH: (Month) September (Day) 20 (Year) 19 54

5. SEX: F

6. COLOR OR RACE: W

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Widow

8. DATE OF BIRTH: Sept. 16, 1877

9. AGE last birthday: 77 yrs. IF UNDER 1 YEAR Months 0 Days 4 IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION..Give kind of work done during most of working life, even if retired): House Work

10b. KIND OF BUSINESS OR INDUSTRY: At Own Home

11. BIRTHPLACE (State or foreign country): Worcester Co. Maryland

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Purnell C. Coulbourn

14. MOTHER'S MAIDEN NAME: Mary Emma Johnson

15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No (If Yes, give war or dates of service)

16. SOCIAL SECURITY No.:

17. INFORMANT & ADDRESS: Mrs. Edna D. Sturgis (Daughter In Law) Crewmor Apts. N. Division St. Salisbury, Maryland

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Coronary Thrombosis — Interval Between Onset And Death: sudden

Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last.
DUE TO (b) Arteriosclerotic C-V Disease — 2 mos
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: 19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☑

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. INJURY OCCURED While at Work ☐ Not While At Work ☐ HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Aug ..., 19 54, to Sept 20, 19 54, that I last saw the deceased alive on Sept 19, 19 54, and that death occurred at 3:30 A.M., from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED
William D. Gray M.D. Salisbury Md 9-20-54

23. BURIAL, CREMATION, REMOVAL (Specify) Burial | DATE THEREOF Sept. 22, 1954 | NAME OF CEMETERY OR CREMATORY Parsons Cemetery | LOCATION (City, town, or county) (State) Salisbury, Maryland

DATE REC'D BY LOCAL REGISTRAR 9-21-54 | REGISTRAR'S SIGNATURE Mary W. Holloway

24. FUNERAL DIRECTOR Walter R. Holloway & Co. Salisbury Md. Walter R. Holloway

RECEIVED
SEP
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 08860

08882

CERTIFICATE OF DEATH

Reg. Dist. No. 336

1. PLACE OF DEATH:
COUNTY Wicomico MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Delmar
LENGTH OF STAY (in this place) 11 yrs
HOSPITAL OR INSTITUTION OR STREET ADDRESS 104 State Street

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland COUNTY Wicomico
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Delmar
STREET ADDRESS (If rural give location) 104 State Street

3. NAME OF DECEASED: (Type or Print) (First) Albert (Middle) Harlan (Last) Elliott

4. DATE OF DEATH: (Month) Sept. (Day) 22 (Year) 19 54

5. SEX: Male
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify) Married
8. DATE OF BIRTH: Oct. 13, 1881
9. AGE last birthday: 72 yrs. IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS.: Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired Merchant
10B. KIND OF BUSINESS OR INDUSTRY: Shoes
11. BIRTHPLACE (State or foreign country): Delmar, Md.
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: William Burton Elliott
14. MOTHER'S MAIDEN NAME: Mary Ellen German

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No (If Yes, give war or dates of service)
16. SOCIAL SECURITY NO. 277-18-6846
17. INFORMANT & ADDRESS: Annie Elliott, Delmar, Md.

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

IMMEDIATE CAUSE (A) Acute pulmonary edema — INTERVAL BETWEEN ONSET AND DEATH: 2 hours

ANTECEDENT CAUSE (S)

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.

DUE TO (B) Hypertensive heart disease with decompensation

DUE TO (C) Hypertension, essential

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

19A. DATE OF OPERATION:
19B. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)
21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY M.
21E. INJURY OCCURRED While at work ☐ Not while at work ☐
21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from ..... 19 48 to Sept 22, 1954, that I last saw the deceased alive on Sept 22, 1954, and that death occurred at 1:30 P.M., from the causes and on the date stated above.

SIGNATURE H. V. Sohler, M. D. ADDRESS 303 East Street, Delmar, Md. DATE SIGNED 9-23-54

23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial
DATE THEREOF 9-25-54
NAME OF CEMETERY OR CREMATORY Union
LOCATION (City, town, or county) (State) Georgetown, Delaware

DATE REC'D BY LOCAL REGISTRAR September 25 54
REGISTRAR'S SIGNATURE Harriet Hudson
24. FUNERAL DIRECTOR ADDRESS W. S. Mason & Son Delmar Del

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15 — 10 - 53

SEP 29

08846 Item 7 Filed 172 10-25-54 ct

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 Reg. Dist. 08861

MEDICAL EXAMINER'S CERTIFICATE OF DEATH No. 332

1. PLACE OF DEATH:
COUNTY Wicomico MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Salisbury
LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Md COUNTY Wicomico
CITY (If outside corporate limits write RURAL and give nearest town) OR TOWN Salisbury
STREET ADDRESS (If rural, give location) 119 First St

3. NAME OF DECEASED: (First) Noah (Middle) (Last) Dale
4. DATE OF DEATH (Month) 9 (Day) 21 (Year) 1954

5. SEX: M
6. COLOR OR RACE: C
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Widowed
8. DATE OF BIRTH:
9. AGE last birthday: 70 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): Laborer
10b. KIND OF BUSINESS OR INDUSTRY: waterman
11. BIRTHPLACE (State or foreign country): Quantico, Md.
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: John Gale
14. MOTHER'S MAIDEN NAME: Catherine ?

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) No
16. SOCIAL SECURITY NO.: 216-14-2029
17. INFORMANT & ADDRESS: Bertha Jones - 119 First St.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:
Immediate cause (a) Compound Fracture of Skull
DUE TO
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating underlying cause last (b) DUE TO (c)
INTERVAL BETWEEN ONSET AND DEATH

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

19a. DATE OF OPERATION:
19b. MAJOR FINDING OF OPERATION:
20. AUTOPSY? Yes ☐ No ☑

21a. EXTERNAL CAUSE WAS PRIMARY ☑ or CONTRIBUTING ☐ CAUSE OF DEATH.
21b. PLACE (Home, farm, factory, OF street, office bldg., etc.) INJURY Street
21c. (City or town) Salisbury (County) Wicomico (State) Md.
21d. TIME OF INJURY (Month) Sept (Day) 21 (Year) 54 (Hour) 8:05 A.M.
21e. INJURY OCCURRED While at work ☐ Not while at work ☑
21f. HOW DID INJURY OCCUR? Struck by auto while walking in Street

22. I hereby certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☑, Inquiry ☐, and find that death resulted from: Natural causes ☐, Accident ☑, Suicide ☐, Homicide ☐, Undetermined cause ☐.
SIGNATURE Earl L. Kreger M. D.
CHIEF MEDICAL EXAMINER ☐ DEPUTY MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAM. ☑
DATE SIGNED 9-25-54

23. BURIAL, CREMATION, REMOVAL (Specify): Burial
DATE THEREOF 9-27-54
NAME OF CEMETERY OR CREMATORY Green Acres Memorial Park
LOCATION (City, town, or county) (State) Salisbury, Wicomico Co. Md.
DATE REC'D BY LOCAL REG. 9-27-54
REGISTRAR'S SIGNATURE Mary M. Holloway
24. FUNERAL DIRECTOR Mary A. Stewart ADDRESS 324 E. Church St.
STEWART FUNERAL HOME Salisbury, Md.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15A - 5 - 53

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 08862

CERTIFICATE OF DEATH

08847

Reg. Dist. No. 332

1. PLACE OF DEATH:
COUNTY Wicomico
CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN Salisbury
MARYLAND
LENGTH OF STAY (in this place) 12
HOSPITAL OR INSTITUTION OR STREET ADDRESS Peninsula General Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland COUNTY Somerset
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Chance.
STREET ADDRESS (If rural give location)

3. NAME OF DECEASED: (First) (Middle) (Last) (Type or Print) Gavarinski

4. DATE OF DEATH: (Month) September (Day) 7 (Year) 1954.

5. SEX: Male

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):

8. DATE OF BIRTH: September 7-54

9. AGE last birthday: yrs. IF UNDER 1 YEAR: Months Days; IF UNDER 24 HRS.: Hours 3 Min.

10a. USUAL OCCUPATION. Give kind of work done during most of working life, even if retired):

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Frank John Gavarinski

14. MOTHER'S MAIDEN NAME: Mary Anna Keatley

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)

16. SOCIAL SECURITY No.:

17. INFORMANT & ADDRESS: Frank Gavarinski

18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — Interval Between Onset And Death

Immediate cause (a) Septicemia

Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last.
(b) Prematurity
(c) Mother had Uterine infection

11. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURED While at Work ☐ Not While At Work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from ....., 19....., to ....., 19....., that I last saw the deceased alive on ....., 19....., and that death occurred at 12:25 P.M. from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED
Morris C. Lambdin M.D. Salisbury, Md. 9-8-54

23. BURIAL, CREMATION, REMOVAL (Specify) DATE THEREOF 9-8-54 NAME OF CEMETERY OR CREMATORY Peninsula General Hospital LOCATION (City, town, or county) (State) Salisbury, Wicomico, Md.

DATE REC'D BY LOCAL REGISTRAR 9-8-54 REGISTRAR'S SIGNATURE Mary W. Holloway

24. FUNERAL DIRECTOR ADDRESS Peninsula General Hospital

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
SEP 10 1954
BUREAU V. I.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08863

08848

CERTIFICATE OF DEATH

Reg. Dist. No. 332

1. PLACE OF DEATH:
COUNTY Wicomico MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Salisbury
LENGTH OF STAY (in this place) 1 Week
HOSPITAL OR INSTITUTION OR STREET ADDRESS Peninsula General Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Md COUNTY Worcester
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Snow Hill
STREET ADDRESS (If rural give location)

3. NAME OF DECEASED: (Type or Print) (First) Horatio (Middle) S. B. (Last) Gibbons

4. DATE OF DEATH: (Month) September (Day) 22 (Year) 1954

5. SEX: Male
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married
8. DATE OF BIRTH: Jan 8-1881
9. AGE last birthday: 73-8-14 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired: Retired Farmer
10b. KIND OF BUSINESS OR INDUSTRY: Own Farm
11. BIRTHPLACE (State or foreign country): Princess Anne Md
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Elijah Gibbons
14. MOTHER'S MAIDEN NAME: Adeline Snyder

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No (If Yes, give war or dates of service)
16. SOCIAL SECURITY No.: None
17. INFORMANT & ADDRESS: Mr Kenneth E. Gibbons, Snow Hill, Md

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

585X

Immediate cause (a) Peritonitis

DUE TO

Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. (b) Acute Cholecystitis

~~DUE TO~~

(c) Hypertensive c-v disease c̄ auricular fibrillation

Interval Between Onset And Death: 7 days

11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: 9-15-54
19b. MAJOR FINDINGS OF OPERATION: Acute cholecystitis.
20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE (Specify)
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURED While at Work ☐ Not While At Work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 9/15/, 1954, to 9/22, 1954, that I last saw the deceased alive on 9-22-, 1954, and that death occurred at 8 1 am, from the causes and on the date stated above.

SIGNATURE William A. Fisher Jr. (Degree or title) ADDRESS DATE SIGNED 9-22-54

23. BURIAL, CREMATION, REMOVAL (Specify): Burial
DATE THEREOF: Sept 24/54
NAME OF CEMETERY OR CREMATORY: Christian
LOCATION (City, town, or county) (State): Snow Hill, Md

DATE REC'D BY LOCAL REGISTRAR: 9-23-54
REGISTRAR'S SIGNATURE: Mary W. Holloway mnt
24. FUNERAL DIRECTOR: Clay E. Emmis, Snow Hill, Md ADDRESS

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

OUREAU V. S.

08849

08864

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 Reg. Dist.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH No. 332

I. PLACE OF DEATH:
COUNTY Wicomico MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Salisbury
LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS 407 Poplar St.

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland COUNTY Wicomico
CITY (If outside corporate limits write RURAL and give nearest town) OR TOWN Salisbury
STREET ADDRESS (If rural, give location) 407 Poplar St.

3. NAME OF DECEASED: (Type or Print) (First) Daisy (Middle) M (Last) Gordy
4. DATE OF DEATH (Month) 9 (Day) 24 (Year) 1954
5. SEX: Female
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Married
8. DATE OF BIRTH: Feb. 6, 1892
9. AGE last birthday: 62 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): House Work
10b. KIND OF BUSINESS OR INDUSTRY: At own Home
11. BIRTHPLACE (State or foreign country): Salisbury(Wicomico Co) Md.
12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME: Marion C. Williams
14. MOTHER'S MAIDEN NAME: Emma Elizabeth Calloway
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)
16. SOCIAL SECURITY NO.:
17. INFORMANT & ADDRESS: Mr. J. Elmer Gordy (Husband) 407 Poplar St. Salisbury, Maryland

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH: INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Cerebral hemorrhage —
DUE TO
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating underlying cause last (b) Hypertensive C.V. disease —
DUE TO
(c)

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

19a. DATE OF OPERATION: 19b. MAJOR FINDING OF OPERATION: 20. AUTOPSY? Yes ☐ No ☑

21a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY
21c. (City or town) (County) (State)
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY M.
21e. INJURY OCCURRED While at work ☐ Not while at work ☐
21f. HOW DID INJURY OCCUR?

22. I hereby certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☑, Inquiry ☑, and find that death resulted from: Natural causes ☑, Accident ☐, Suicide ☐, Homicide ☐, Undetermined cause ☐.

SIGNATURE Emil Hoyer M. D.
CHIEF MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAM. ☑
DATE SIGNED 9-25-54

23. BURIAL, CREMATION, REMOVAL (Specify): Burial
DATE THEREOF Sept. 28, 1954
NAME OF CEMETERY OR CREMATORY Wicomico Memorial Park
LOCATION (City, town, or county) (State) Salisbury, Maryland

DATE REC'D BY LOCAL REG. 9-28-54
REGISTRAR'S SIGNATURE Mary M. Holloway
24. FUNERAL DIRECTOR HOLLOWAY & COMPANY ADDRESS SALISBURY MARYLAND

Walter R. Holloway

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the noses of death clearly and legibly.

VS. A15A - 5 - 53

RECEIVED
SEP 30 1924
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08850 08865

CERTIFICATE OF DEATH

Reg. Dist. No. 332

Item 9, FilmG170A 10-4-54 E.

1. PLACE OF DEATH:

COUNTY Wicomico MARYLAND

CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Salisbury

LENGTH OF STAY (in this place)

HOSPITAL OR INSTITUTION OR STREET ADDRESS Peninsula General Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE Maryland COUNTY Wicomico

CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN ~~405 Commerce St~~ Salisbury Md

STREET ADDRESS (If rural, give location) ~~Sated~~ 405 Commerce St

3. NAME OF DECEASED: (Type or Print) (First) Addie (Middle) (Last) Harmon

4. DATE OF DEATH: (Month) Sept. (Day) 19 (Year) 1954

5. SEX: female

6. COLOR OR RACE: negoe

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): married

8. DATE OF BIRTH: 1918

9. AGE last birthday: 2811 36 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): none

10b. KIND OF BUSINESS OR INDUSTRY: None

11. BIRTHPLACE (State or foreign country): Winsor N.C.

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Lewis Gilliam

14. MOTHER'S MAIDEN NAME: Alberta Larry

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)

16. SOCIAL SECURITY NO.: ? ?

17. INFORMANT & ADDRESS: Lewis Gilliam

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

Immediate cause (a) Sunshot Wound of Face and Skull — INTERVAL BETWEEN ONSET AND DEATH: 2-3 hours

DUE TO

Antecedent cause(s) (b)

Diseases or conditions, if any, giving rise to the above cause stating underlying cause last

DUE TO

(c)

II. OTHER SIGNIFICANT CONDITIONS: Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? Yes ☒ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify) homicide

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) home

(CITY OR TOWN) Salisbury (COUNTY) Wicomico (STATE) Maryland

TIME OF INJURY (Month) (Day) (Year) (Hour) Sept 19, 1954 4:15 M.

INJURY OCCURRED While at work ☐ Not while at work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I ~~attended~~ examined the deceased from on Sept 19, 1954, to ~~....., 19....~~, that I last saw the deceased ~~alive~~ deed on Sept 19, 1954, and that death occurred at ..... m., from the causes and on the date stated above.

SIGNATURE Kendrick McCullough (DEGREE OR TITLE) M.D. ADDRESS Acting Deputy Medical Examiner for Wicomico County DATE SIGNED Sept 24, 1954

23. BURIAL, CREMATION REMOVAL (Specify): Burial DATE THEREOF Sept 28, 54 NAME OF CEMETERY OR CREMATORY Bevins Cem LOCATION (City, town, or county) Fruitland Md. (State)

DATE REC'D BY LOCAL REG. 9-28-54 REGISTRAR'S SIGNATURE Mary W. Holloway

24. FUNERAL DIRECTOR Booker M Cook ADDRESS

VS. A15 8-51

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
SEP 30 1954
BUREAU V

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 08866

08851

CERTIFICATE OF DEATH

Reg. Dist. No. 332

1. PLACE OF DEATH:

COUNTY Wicomico MARYLAND

CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Salisbury 12

LENGTH OF STAY (in this place) 2 Mo.

HOSPITAL OR INSTITUTION OR STREET ADDRESS Peninsula General Hospital 20

2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE Maryland COUNTY Wicomico

CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Salisbury 12

STREET ADDRESS (If rural give location) Home for Aged, Lemon Hill

3. NAME OF DECEASED: (Type or Print) (First) Annie (Middle) Hancock (Last) Harrigan

4. DATE OF DEATH: (Month) Sept. (Day) 20 (Year) 1954

5. SEX: Female

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Widowed

8. DATE OF BIRTH: Oct 11, 1871

9. AGE last birthday: 82 yrs. IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS.: Hours Min.

10a. USUAL OCCUPATION Give kind of work done during most of working life, [redacted] Housewife

10b. KIND OF BUSINESS OR INDUSTRY: Own Home

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY: U.S.A.

13. FATHER'S NAME: John Hancock

14. MOTHER'S MAIDEN NAME: Elizabeth Riddin

15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No (If Yes, give war or dates of service) —

16. SOCIAL SECURITY No.:

17. INFORMANT & ADDRESS: John B. Parsons, Salisbury, Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Arteriosclerotic Heart Disease — Interval Between Onset And Death: 2 months

DUE TO

Antecedent causes(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. (b)

DUE TO

(c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify)

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURED While at Work ☐ Not While At Work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 1950, 19 , to 9/20, 1954, that I last saw the deceased alive on 9/20, 1954, and that death occurred at 6:30 AM, from the causes and on the date stated above.

SIGNATURE Fred A. Aramse (Degree or title) M.D. ADDRESS Salisbury, Md. DATE SIGNED 9/20/54

26. BURIAL, CREMATION, REMOVAL (Specify) Burial

DATE THEREOF 9/22/54

NAME OF CEMETERY OR CREMATORY Stockton Presbyterian Cem.

LOCATION (City, town, or county) (State) Stockton, Maryland

DATE REC'D BY LOCAL REGISTRAR 9-20-54

REGISTRAR'S SIGNATURE Mary W. Holloway

24. FUNERAL DIRECTOR Hill & Johnson Co. ADDRESS Salisbury, Md. George C. Hill II

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

SEP
BUREAU

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 08867

08852 CERTIFICATE OF DEATH Reg. Dist. No. 332

1. PLACE OF DEATH:
COUNTY Wicomico MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Salisbury R 5 | LENGTH OF STAY (in this place) 7 days
HOSPITAL OR INSTITUTION OR STREET ADDRESS Peninsula General Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland COUNTY Worcester
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Berlin R 1
STREET ADDRESS (If rural give location)

3. NAME OF DECEASED: (Type or Print) (First) LOLA (Middle) (Last) HASTINGS
4. DATE OF DEATH: (Month) (Day) (Year) SEPTEMBER 6 1954
5. SEX: F
6. COLOR OR RACE: W
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):
8. DATE OF BIRTH: NOV. 22nd 1926
9. AGE last birthday: 28 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY: Home
11. BIRTHPLACE (State or foreign country): Newark Md.
12. CITIZEN OF WHAT COUNTRY? U S A
13. FATHER'S NAME: George Whitman
14. MOTHER'S MAIDEN NAME: Lillian Lantz
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)
16. SOCIAL SECURITY NO.:
17. INFORMANT & ADDRESS: Mr Norman Whitman Berlin, Md.

18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH
Immediate cause (a) Congenital Mitral & Aortic Valvular — Interval Between Onset And Death 20 yrs
Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. DUE TO (b) Disease
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Bronchiectasis — 5 yrs

19a. DATE OF OPERATION: 19b. MAJOR FINDINGS OF OPERATION 20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE (Specify) PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m. INJURY OCCURED While at Work ☐ Not While At Work ☐ HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 9-2-54, 19..., to Sept. 7, 19..., that I last saw the deceased alive on 9-6-54, 19..., and that death occurred at 6:25 A.M., from the causes and on the date stated above.
SIGNATURE (Degree or title) ADDRESS DATE SIGNED
Lee L Lewis M.D. Fruitland Md 9-7-54

23. BURIAL, CREMATION, REMOVAL (Specify) DATE THEREOF 9-8-54 NAME OF CEMETERY OR CREMATORY Bowen Cemetery LOCATION (City, town, or county) (State) Newark, Md.
DATE REC'D BY LOCAL REGISTRAR 9-8-54 REGISTRAR'S SIGNATURE Mary W. Holloway
24. FUNERAL DIRECTOR ADDRESS Anna A. Burbage, Berlin, Md
Per M.W.H.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
SEP 10
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08853 **CERTIFICATE OF DEATH** 08868

Reg. Dist. No. 332

1. PLACE OF DEATH:
COUNTY Wicomico MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Salisbury
LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS Peninsula General Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland COUNTY Wicomico
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Delmar L.
STREET ADDRESS (If rural give location) R.T. 3

3. NAME OF DECEASED: (Type or Print) (First) Lawrence (Middle) D (Last) Hill

4. DATE OF DEATH: (Month) September (Day) 27 (Year) 1954

5. SEX: M
6. COLOR OR RACE: W
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Married
8. DATE OF BIRTH: Jan 21, 1914
9. AGE last birthday: 40 yrs. IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS.: Hours Min.

10a. USUAL OCCUPATION. Give kind of work done during most of working life, even if retired): Mechanic
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: James B. Hill
14. MOTHER'S MAIDEN NAME: Mary Nichols

15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)
16. SOCIAL SECURITY No.: 220-01-7208
17. INFORMANT & ADDRESS: Marshall Hill Princess Anne Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Coronary Artery Thrombosis — Interval Between Onset And Death: 3 hours

DUE TO

Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. (b) Coronary Artery Heart Disease — 3 months

DUE TO

(c)

11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify)
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURED While at Work ☐ Not While At Work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from July 28, 1954, to Sept. 27, 1954, that I last saw the deceased alive on Sept. 27, 1954 and that death occurred at 6:35 P.M. from the causes and on the date stated above.

SIGNATURE (Degree or title) David J. Gilmore M.D. ADDRESS Salisbury Md. DATE SIGNED Sept. 27, 1954

23. BURIAL, CREMATION, REMOVAL (Specify) burial
DATE THEREOF Sept 30, 1954
NAME OF CEMETERY OR CREMATORY Episcopal Cemetery
LOCATION (City, town, or county) Princess Anne (State) Md
DATE REC'D BY LOCAL REGISTRAR 9-29-54
REGISTRAR'S SIGNATURE Mary W. Holloway
24. FUNERAL DIRECTOR James Dinman ADDRESS Princess Anne, Md

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
OCT 11 1954
BUREAU V[illegible]

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08854

CERTIFICATE OF DEATH

08869

Reg. Dist. No. 532

Item 9, Film G171 10-15-54 et

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH:

COUNTY Wicomico — MARYLAND

CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Salisbury

LENGTH OF STAY (in this place) 1½ days

HOSPITAL OR INSTITUTION OR STREET ADDRESS Peninsula General Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE Virginia — COUNTY Accomac

CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Atlantic

STREET ADDRESS (If rural give location)

3. NAME OF DECEASED: (Type or Print) (First)	(Middle)	(Last)	4. DATE OF DEATH: (Month)	(Day)	(Year)
Carrie	White	Holland	9	26	1954

5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH:	9. AGE last birthday:	IF UNDER 1 YEAR: Months	Days	IF UNDER 24 HRS.: Hours	Min.
F	W	Married	Oct 31, 1887	66 Yrs.				

10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired):	10b. KIND OF BUSINESS OR INDUSTRY:	11. BIRTHPLACE (State or foreign country):	12. CITIZEN OF WHAT COUNTRY?
Housewife		Quinby, Va.	U S A

13. FATHER'S NAME:	14. MOTHER'S MAIDEN NAME:
Hugh White	Maggie Mears

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)	16. SOCIAL SECURITY No.:	17. INFORMANT'S ADDRESS:
		Mrs. Reade Miles, Atlantic, Va.

18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — Interval Between Onset And Death

Immediate cause (a) Carcinoma of Pancreas — 6 Mos. Aff.

DUE TO

Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last.

(b) DUE TO

(c)

11. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
None		Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)	PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	(CITY OR TOWN)	(COUNTY)	(STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour)	INJURY OCCURED While at Work ☐ Not While At Work ☐	HOW DID INJURY OCCUR?
m.		

22. I hereby certify that I attended the deceased from Sep 5 24, 1954, to Sep 5 26, 1954, that I last saw the deceased alive on Sep 5 26, 1954, and that death occurred at 2:35 a.m., from the causes and on the date stated above.

SIGNATURE (Degree or title)	ADDRESS	DATE SIGNED
John Madison Bloxom III	324 N. Division St. Salisbury, Md.	9/26/54

23. BURIAL, CREMATION, REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town or county) (State)
	9-27-54	Downing Cemetery	Oak Hall Va

DATE REC'D BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
9-27-54	Mary W. Holloway	W. M. B. Dalyer	Chincoteague, Va

Per M.W.H.

RECEIVED
SEP 29
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08855 **CERTIFICATE OF DEATH** Reg. Dist. No. 08870

M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH: COUNTY Wicomico MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Salisbury | LENGTH OF STAY (in this place) 3 yrs
HOSPITAL OR INSTITUTION OR STREET ADDRESS Peninsula Gen. Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Wicomico
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Wetipquin
STREET ADDRESS (If rural give location) RR #1

3. NAME OF DECEASED: (Type or Print) (First) Bessie (Middle) H. (Last) Horner
4. DATE OF DEATH: (Month) 9 (Day) 2 (Year) 1954
5. SEX: F
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Married
8. DATE OF BIRTH: 28 Feb. 1885
9. AGE last birthday: 69 yrs. IF UNDER 1 YEAR Months 6 Days 4 IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired): House Wife
10b. KIND OF BUSINESS OR INDUSTRY: Own Home
11. BIRTHPLACE (State or foreign country): Laurel, Delaware
12. CITIZEN OF WHAT COUNTRY? U.S.
13. FATHER'S NAME: Napoleon Hearne
14. MOTHER'S MAIDEN NAME: Martha E. Jones
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No (If Yes, give war or dates of service) —
16. SOCIAL SECURITY NO.: —
17. INFORMANT & ADDRESS: Harry Horner, Wetipquin, Md.

18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

170X

Immediate cause (a) Carcinomatosis — Interval Between Onset And Death: 3 years

DUE TO

Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. (b) Carcinoma Right Breast — 14 years

DUE TO

(c)

11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Incarceration. — 1 month

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify) | PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m. | INJURY OCCURED While at Work ☐ Not While At Work ☐ | HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 6/23, 1954, to 9/2, 1954, that I last saw the deceased alive on 9/2, 1954; and that death occurred at 4:30 A.M., from the causes and on the date stated above.

SIGNATURE Richard H. Saunders M.D. (Degree or title) ADDRESS Nanticoke Md. DATE SIGNED 9/3/54.

23. BURIAL, CREMATION, REMOVAL (Specify) Burial | DATE THEREOF 9/3/54 | NAME OF CEMETERY OR CREMATORY Wetipquin Cem. | LOCATION (City, town, or county) (State) Wetipquin, Maryland
DATE REC'D BY LOCAL REGISTRAR 9-3-54 | REGISTRAR'S SIGNATURE Mary W. Holloway | 24. FUNERAL DIRECTOR Cornelius G. Messick, Bivalve, Md. ADDRESS

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 08871

08883

CERTIFICATE OF DEATH

Reg. Dist. No. 332

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1 PLACE OF DEATH:
COUNTY Wicomico — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Allen
LENGTH OF STAY (in this place) 60 Yrs.
HOSPITAL OR INSTITUTION OR STREET ADDRESS Rt. ~/

2 USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland — COUNTY Wicomico
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Allen
STREET ADDRESS (If rural give location) Rt.

3. NAME OF DECEASED: (Type or Print) (First) Jonathan (Middle) (Last) Huffington

4. DATE OF DEATH: (Month) 9 (Day) (Year) 1954

5. SEX: Male

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Widowed

8. DATE OF BIRTH: April 2[illegible],1862

9. AGE last birthday: 92 yrs. IF UNDER 1 YEAR: Months Days; IF UNDER 24 HRS.: Hours Min.

10a. USUAL OCCUPATION. Give kind of work done during most of working life, even if retired: Retired Farmer

10b. KIND OF BUSINESS OR INDUSTRY: Own Farm

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U. S.

13. FATHER'S NAME: Jesse Huffington

14. MOTHER'S MAIDEN NAME: Ester Parker

15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No (If Yes, give war or dates of service)

16. SOCIAL SECURITY No.: None

17. INFORMANT & ADDRESS: Clifford Huffington, Allen, Maryland

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Congestive Heart Failure — Interval Between Onset And Death: 6 days

Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. DUE TO (b) Senility

DUE TO (c)

11. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: 19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. INJURY OCCURED While at Work ☐ Not While At Work ☐ HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 8-1-54, 19.., to 9-8-54, 19.., that I last saw the deceased alive on 9-7-54, 19.., and that death occurred at 6 A.M., from the causes and on the date stated above.

SIGNATURE (Degree or title) Lee L Lawry M.D. ADDRESS Fruitland, Md. DATE SIGNED 9-10-54

23. BURIAL, CREMATION, REMOVAL (Specify) Burial — DATE THEREOF 9/11/54 — NAME OF CEMETERY OR CREMATORY Allen Cemetery — LOCATION (City, town, or county) (State) Allen, Maryland

DATE REC'D BY LOCAL REGISTRAR 9-13-54 — REGISTRAR'S SIGNATURE Mary W. Holloway

24. FUNERAL DIRECTOR The Hill & Johnson Co. Salisbury, Md. ADDRESS George C Hill II

VS. A15

SEP
BUREAU U. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08884

CERTIFICATE OF DEATH

08872

Reg. Dist. No. 332

1. PLACE OF DEATH:

COUNTY Nicomico MARYLAND

CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN SALISBURY

LENGTH OF STAY (in this place) 3½ mo

HOSPITAL OR INSTITUTION OR STREET ADDRESS Deer's Head State Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE Md. COUNTY Montgomery

CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Silver Springs.

STREET ADDRESS (If rural, give location) 1614 Moffet Rd.

3. NAME OF DECEASED: (Type or Print) (First) EMMA (Middle) ELIZABETH (Last) JEFFERSON

4. DATE OF DEATH: (Month) Sept. (Day) 26 (Year) 1954

5. SEX: F

6. COLOR OR RACE: W.

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Widowed

8. DATE OF BIRTH: 4-9-1878

9. AGE last birthday: 78 yrs. IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Cook

10b. KIND OF BUSINESS OR INDUSTRY: Restaurant

11. BIRTHPLACE (State or foreign country): St. Michaels, Md. USA.

12. CITIZEN OF WHAT COUNTRY? USA.

13. FATHER'S NAME: THEODORE NOSKEY

14. MOTHER'S MAIDEN NAME: MANSFELDT

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)

16. SOCIAL SECURITY NO.:

17. INFORMANT & ADDRESS: Hospital records.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Recurrent cerebral thrombosis	9h.
DUE TO		
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating underlying cause last	(b) Arteriosclerosis general	?
DUE TO		
	(c)	

260 X1

II. OTHER SIGNIFICANT CONDITIONS: Conditions contributing to the death but not related to the disease or condition causing death. Diabetes mellitus ?

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify)

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) M.

INJURY OCCURRED While at work ☐ Not while at work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 6/7, 1954, to 9/26, 1954, that I last saw the deceased alive on 9/26, 1954, and that death occurred at 7 15 p.m., from the causes and on the date stated above.

SIGNATURE Dr. Jeuerman (DEGREE OR TITLE) M.D. ADDRESS Deer's Head State Hospital, Salisbury, Md. DATE SIGNED 9/26/54

23. BURIAL, CREMATION REMOVAL (Specify) Burial

DATE THEREOF Sept 29, 1954

NAME OF CEMETERY OR CREMATORY Springhill Cemetery

LOCATION (City, town, or county) (State) Easton, Md

DATE REC'D BY LOCAL REG. 9-28-54

REGISTRAR'S SIGNATURE Mary W. Holloway

24. FUNERAL DIRECTOR S. Hamilton Harrison ADDRESS St. Michaels Md

VS. A15 8-51

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
SEP 30 1954
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08856

CERTIFICATE OF DEATH

08873

Reg. Dist. No. 332

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15 8-54

1. PLACE OF DEATH:
COUNTY Wicomico
CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN Salisbury
LENGTH OF STAY (in this place) MARYLAND
HOSPITAL OR INSTITUTION OR STREET ADDRESS Peninsula General Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland COUNTY Wicomico
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Nanticoke
STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED: (Type or Print) (First) Lena (Middle) (Last) Johnson.

4. DATE OF DEATH: (Month) (Day) (Year) September 22 54

5. SEX: Female

6. COLOR OR RACE: Colored

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):

8. DATE OF BIRTH: July 17 1894

9. AGE last birthday: 60 yrs.
IF UNDER 1 YEAR Months Days
IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Cook

10b. KIND OF BUSINESS OR INDUSTRY: Food

11. BIRTHPLACE (State or foreign country): Nanticoke Md.

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Henry Thomas

14. MOTHER'S MAIDEN NAME: Laura Nutter

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 134-01-1943

17. INFORMANT & ADDRESS: John Elzey, Nanticoke, Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Cerebral Hemorrhage DUE TO — 1 week

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating underlying cause last (b) Hypertension DUE TO — 2 yrs.

(c)

II. OTHER SIGNIFICANT CONDITIONS: Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify)

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) M.

INJURY OCCURRED While at work ☐ Not while at work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 9/18, 1954, to 9/22, 1954, that I last saw the deceased alive on 9/22, 1954, and that death occurred at 6 P. m., from the causes and on the date stated above.

SIGNATURE E M Beardsley (DEGREE OR TITLE) M D ADDRESS Salisbury, Md. DATE SIGNED 9/23/54

23. BURIAL, CREMATION REMOVAL (Specify): Burial

DATE THEREOF Sept 26 1954

NAME OF CEMETERY OR CREMATORY Nanticoke Cemetery

LOCATION (City, town, or county) Nanticoke, Md. (State)

DATE REC'D BY LOCAL REG. 9-25-54

REGISTRAR'S SIGNATURE Mary Lib Holloway

24. FUNERAL DIRECTOR Leon R. Wilson ADDRESS Princess Anne, Md.

RECEIVED
SEP 28 1934
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 08874

08885

CERTIFICATE OF DEATH

Reg. Dist. No. 332

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
COUNTY Wicomico
CITY (If outside corporate limits, write RURAL) OR TOWN Pocomoke
LENGTH OF STAY (in this place) Lifetime
HOSPITAL OR INSTITUTION OR STREET ADDRESS

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland COUNTY Wicomico
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Pocomoke
STREET ADDRESS (If rural give location)

3. NAME OF DECEASED: (Type or Print) (First) Hattie (Middle) P. (Last) Jones

4. DATE OF DEATH: (Month) Sept (Day) 9 (Year) 1954

5. SEX: F

6. COLOR OR RACE: Colored

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Widowed

8. DATE OF BIRTH: April 10 1877

9. AGE last birthday: 77 yrs. IF UNDER 1 YEAR Months Days; IF UNDER 24 HRS Hours Min.

10a. USUAL OCCUPATION. Give kind of work done during most of working life, even if retired): House Wife

b. KIND OF BUSINESS OR INDUSTRY: Own Home

11. BIRTHPLACE (State or foreign country): Pocomoke City Md.

12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: George Nutter

14. MOTHER'S MAIDEN NAME: Henrietta Nutter

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No (If Yes, give war or dates of service)

16. SOCIAL SECURITY NO.:

17. INFORMANT'S ADDRESS: Mrs Sue Mowbray, Pocomoke, Md.

18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Carcinoma Descending Colon. DUE TO

Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. (b) DUE TO

(c)

Interval Between Onset And Death: 1 Years.

153X

11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Incontinence 3 months

19a. DATE OF OPERATION: 19b. MAJOR FINDINGS OF OPERATION 20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify) PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. INJURY OCCURED While at Work ☐ Not While At Work ☐ HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 14 Oct., 1949, to 9 Sept., 1954, that I last saw the deceased alive on 9 Sept., 1954, and that death occurred at 5.40 P.M., from the causes and on the date stated above.

SIGNATURE Della H. Saunders (Degree or title) M.D. ADDRESS Pocomoke DATE SIGNED 9 Sept 54.

23. BURIAL, CREMATION, REMOVAL (Specify) Burial DATE THEREOF 9/11/54 NAME OF CEMETERY OR CREMATORY Pocomoke Cem. LOCATION (City, town, or county) Pocomoke (State) Md.

DATE REC'D BY LOCAL REGISTRAR 9-11-54 REGISTRAR'S SIGNATURE Mary M. Holloway

24. FUNERAL DIRECTOR Cornelius D. Pessick ADDRESS Berlin, Md.

VS. A15

MARYLAND STATE DEPARTMENT OF HEALTH

08875

08886

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 332

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH
COUNTY Wicomico — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Willards
LENGTH OF STAY (in this place) 11 years
HOSPITAL OR INSTITUTION OR STREET ADDRESS

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE Md. COUNTY Wicomico
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Willards
STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print): (First) William (Middle) Parlett (Last) Ketterman

4. DATE OF DEATH: (Month) Sept. (Day) 21 (Year) 1954

5. SEX: Male

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married

8. DATE OF BIRTH: June 18, 1890

9. AGE last birthday: 64 yrs. If under 1 year: Months / Days / If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farming

10b. KIND OF BUSINESS OR INDUSTRY: Own farm

11. BIRTHPLACE (State or foreign country): Timbert Ridge, W. Va.

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: W. M. Ketterman

14. MOTHER'S MAIDEN NAME: Dena Lacie

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no
(If year, give war or dates of service)

16. SOCIAL SECURITY NO.: 215-20-2297

17. INFORMANT AND ADDRESS: Laura Ketterman, Willards, Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Myocarditis Chronic. — Interval Between Onset and Death: 2 yrs.

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Arteriosclerosis

(c)

(260X)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Diabetes mellitus — 5 yrs

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☑

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY — (CITY OR TOWN) — (COUNTY) — (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 9-5, 1954, to 9-21, 1954, that I last saw the deceased alive on 9-20, 1954, and that death occurred at 5:30 P m., from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED

Frank R. Lewis M.D. Willards Md. 9-22-54

23. BURIAL, CREMATION, REMOVAL (Specify): Burial — DATE: 9/24/54 — NAME OF CEMETERY OR CREMATORY: Riverside Cem. — LOCATION (City, town, or county) (State): near Berlin Md.

DATE REC'D BY LOCAL REG. 9-24-54 — REGISTRAR'S SIGNATURE: Mary W. Holloway

24. FUNERAL DIRECTOR: Henry W. Watson Jr. — ADDRESS: Pocomoke Md.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08887

CERTIFICATE OF DEATH

08876

Reg. Dist. No. 332

1. PLACE OF DEATH: COUNTY Wicomico MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury
LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS R.D.# 5 110 Louise Ave.

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Wicomico
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury
STREET ADDRESS (If rural give location) R.D. # 5 110 Louise Ave.

3. NAME OF DECEASED: (Type or Print) (First) WILLIAM (Middle) LEONHARDT (Last) CHARLES LANG

4. DATE OF DEATH: (Month) SEPT. (Day) 22 (Year) 1954

5. SEX: Male
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Married
8. DATE OF BIRTH: Mar. 5, 1897
9. AGE last birthday: 57 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired) Sales Manager-
10b. KIND OF BUSINESS OR INDUSTRY: Electric Public Service Co.
11. BIRTHPLACE (State or foreign country): Wilmington, Delaware
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Fredrick Lang (Born in Germany)
14. MOTHER'S MAIDEN NAME: Margaret Leonhardt (Born in Germany)

15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) Yes. (If Yes, give war or dates of service) W W # I
16. SOCIAL SECURITY No.:
17. INFORMANT & ADDRESS: Mrs. Carrie W. Lang (Wife) R.D.# 5 110 Louise Ave. Salisbury, Maryland

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

420.1

Immediate cause (a) Coronary Occlusion

DUE TO

Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. (b) Arterio sclerotic C. V. Disease

DUE TO

(c)

Interval Between Onset And Death: yrs

11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE (Specify)
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURED While at Work ☐ Not While At Work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from August, 1957, to Sept, 1957, that I last saw the deceased alive on 22 Sept, 1957, and that death occurred at 11:00 P.M., from the causes and on the date stated above.

SIGNATURE (Degree or title) Earl W. Rogers M.D.
ADDRESS Salisbury, Maryland
DATE SIGNED Sept. 25 1954

23. BURIAL, CREMATION, REMOVAL (Specify) Burial
DATE THEREOF Sept. 27, 1954
NAME OF CEMETERY OR CREMATORY Riverview Cemetery
LOCATION (City, town, or county) (State) Wilmington, Delaware

DATE REC'D BY LOCAL REGISTRAR 9-25-54
REGISTRAR'S SIGNATURE Mary W. Holloway

24. FUNERAL DIRECTOR HOLLOWAY & COMPANY
ADDRESS SALISBURY MARYLAND

Walter R. Holloway

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

SEP 13 '4
BUREAU V.

08857

08877

MARYLAND STATE DEPARTMENT OF HEALTH

Items 18&21 Film G170A 10-4-54 BS

CERTIFICATE OF DEATH
FOR MEDICAL EXAMINERS

Reg. Dist. No. 33

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15A

1. PLACE OF DEATH: COUNTY Wicomico — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Salisbury — LENGTH OF STAY (In this place) 3 days
HOSPITAL OR INSTITUTION OR STREET ADDRESS Peninsula General Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland — COUNTY Somerset
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Princess Anne R.F.D.
STREET ADDRESS (If rural, give location) Polks Road

3. NAME OF DECEASED (Type or Print): (First) Archie (Middle) Leatherbury (Last)

4. DATE OF DEATH: (Month) Sept (Day) 23 (Year) 1954

5. SEX: Male

6. COLOR OR RACE: Colored

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Married

8. DATE OF BIRTH: 4/18/1921

9. AGE last birthday: 33 yrs. — If under 1 year: Months — Days — If under 24 hrs.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farmer

10b. KIND OF BUSINESS OR INDUSTRY: Farm

11. BIRTHPLACE (State or foreign country): Polk Road

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Samuel Leatherbury

14. MOTHER'S MAIDEN NAME: Ida Hale

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): No

16. SOCIAL SECURITY NO.: 220-01-9460

17. INFORMANT AND ADDRESS: Mathew Leatherbury -

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Acute Laryngeal and Tracheal edema — Interval Between Onset and Death: 30 minutes

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(b) Pulmonary edema

(c) Plastic Operation for neck

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. a) Burn of chest, neck, chin and left hand

19a. DATE OF OPERATION: Sept 23. 1954

19b. MAJOR FINDINGS OF OPERATION: Freeing of contracted tissue following burn -

20. AUTOPSY? Yes ☐ No ☑

21. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

PLACE (Home, farm, factory, street, office, bldg., etc.) OF INJURY Home

(CITY OR TOWN) Princess Anne R.F.D. (COUNTY) Somerset (STATE) Maryland

TIME OF INJURY (Month) April (Day) 27th (Year) 1954 (Hour) 11 A m.

INJURY OCCURRED While at work ☐ Not while at work ☑

HOW DID INJURY OCCUR? (If in motor vehicle accident, state whether driver or passenger.) Patient fell asleep while smoking in bed, dozed off and ignited bedclothes -

22. *I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☑, Inquiry ☑ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐ accident ☑, suicide ☐, homicide ☐, undetermined ☐*

SIGNATURE: R. Todd Owens M.D. (Degree or title) Deputy Medical Exam - ADDRESS Princess Anne Md DATE SIGNED Sept 24. 1954

23. BURIAL, CREMATION OR REMOVAL (Specify): Burial — DATE THEREOF: 9/26/54 — NAME OF CEMETERY OR CREMATORY: Family — LOCATION (City, town, or county) (State): Polk Road, Md

DATE REC'D BY LOCAL REG. 9-24-54 — REGISTRAR'S SIGNATURE: Mary M. Holloway

24. FUNERAL DIRECTOR: William H. James Jr. — ADDRESS: Princess Anne Md

Dunn

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08878

CERTIFICATE OF DEATH

Reg. Dist. No. 332

08858

Item 8 Film G170 9-20-54 et

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15 8-51

1. PLACE OF DEATH:
COUNTY Wicomico — MARYLAND
CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN Salisbury — LENGTH OF STAY (in this place) 1 Y
HOSPITAL OR INSTITUTION OR STREET ADDRESS R&C Peninsula General Hosp

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland COUNTY Somerset
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Princess Anne R.F.D.
STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED: (Type or Print) (First) Sally (Middle) Elizabeth (Last) Long

4. DATE OF DEATH: (Month) 9 (Day) 21 (Year) 1954

5. SEX: F

6. COLOR OR RACE: W

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Widowed

8. DATE OF BIRTH: 12-10-1886

9. AGE last birthday: 58 yrs. — IF UNDER 1 YEAR: Months / Days; IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Home

10b. KIND OF BUSINESS OR INDUSTRY: None

11. BIRTHPLACE (State or foreign country): Sagerstown Pa. U.S.A.

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: David Buck

14. MOTHER'S MAIDEN NAME: Susana Buck

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) N — (If Yes, give war or dates of service) No

16. SOCIAL SECURITY NO.: No

17. INFORMANT & ADDRESS: C. Walter Long, Princess Anne Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

331X

Immediate cause (a) Cerebral vascular accident — INTERVAL BETWEEN ONSET AND DEATH: 20 hrs

DUE TO

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating underlying cause last (b) arteriosclerosis — 3 years

DUE TO

(c)

II. OTHER SIGNIFICANT CONDITIONS: Conditions contributing to the death but not related to the disease or condition causing death. Congestive heart failure

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) M.

INJURY OCCURRED While at work ☐ Not while at work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 8-24, 1954 to 9-21, 1954 that I last saw the deceased alive on 9-21, 1954, and that death occurred at 7 p.m., from the causes and on the date stated above.

SIGNATURE George M Lunn M.D. (DEGREE OR TITLE) ADDRESS Princess Anne Md DATE SIGNED 9-23-54

23. BURIAL, CREMATION, REMOVAL (Specify): Burial — DATE THEREOF Sept 24/1954 — NAME OF CEMETERY OR CREMATORY Manokin Presbyterian Cemetery — LOCATION (City, town, or county) Princess Anne (State) Md

DATE REC'D BY LOCAL REG. 9-24-54 — REGISTRAR'S SIGNATURE Mary M. Holloway — FUNERAL DIRECTOR Lewis R. Watson — ADDRESS Princess Anne, Md.

RECEIVED
SEP 27 1954
BUREAU V. S.

08888 08879

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 336

1. PLACE OF DEATH: COUNTY Wicomico MARYLAND	2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Wicomico
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Delmar — LENGTH OF STAY (in this place) 81 yrs	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Delmar
HOSPITAL OR INSTITUTION OR STREET ADDRESS 306 Elizabeth St.	STREET ADDRESS (If rural, give location) 306 Elizabeth Street

3. NAME OF DECEASED (Type or Print)	(First) Louisa	(Middle) Ellen	(Last) Lowe	4. DATE OF DEATH	(Month) Sept.	(Day) 4	(Year) 1954
5. SEX Female	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Widowed	8. DATE OF BIRTH 8-24-1873	9. AGE last birthday 81 yrs.	If under 1 year Months / Days	If under 24 hrs. Hours / Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) At Home	10b. KIND OF BUSINESS OR INDUSTRY Home	11. BIRTHPLACE (State or foreign country) Delmar, Md.	12. CITIZEN OF WHAT COUNTRY? USA				
13. FATHER'S NAME Unknown	14. MOTHER'S MAIDEN NAME Unknown						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No or unknown) No (If yes, give war or dates of service)	16. SOCIAL SECURITY NO. None	17. INFORMANT AND ADDRESS Levin Lowe, Delmar, Del.					

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) MESENTERIC THROMBOSIS	3 days
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b)	
	(c) ARTERIOSCLEROSIS	?

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION —	19b. MAJOR FINDINGS OF OPERATION —	20. AUTOPSY? Yes ☐ No ☑
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	(CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 9-2, 1954, to death, 19....., that I last saw the deceased alive on 9-4, 1954, and that death occurred at 8 A.m., from the causes and on the date stated above.

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
[illegible]	M.D.	Delmar, Del.	1/4/54

23. BURIAL, ~~CREMATION~~ REMOVAL (Specify) Burial	DATE THEREOF 9-6-54	NAME OF CEMETERY OR ~~CREMATORY~~ Nichols	LOCATION (City, town, or county) (State) Delmar, Del.
DATE REC'D BY LOCAL REG. Sept. 4, 1954	REGISTRAR'S SIGNATURE Harry E. Hudson Sr.	24. FUNERAL DIRECTOR W. S. Mannel Co.	ADDRESS Delmar, Del.

VS. A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
SEP
PUBLIC V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 08880

08859

CERTIFICATE OF DEATH

Reg. Dist. No. 332

1. PLACE OF DEATH:
COUNTY Wicomico MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Salisbury
LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS Peninsula General Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Delaware COUNTY Sussex
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Selbyville
STREET ADDRESS (If rural give location)

3. NAME OF DECEASED: (Type or Print) (First) Junius (Middle) (Last) Mack.

4. DATE OF DEATH: (Month) (Day) (Year) September 19 1954

5. SEX: Male
6. COLOR OR RACE: Colored.
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):
8. DATE OF BIRTH: Feb 18, 1931
9. AGE last birthday: 23 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS Hours Min.

10a. USUAL OCCUPATION. Give kind of work done during most of working life, even if retired): Unknown
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Unknown
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Unknown
14. MOTHER'S MAIDEN NAME: Unknown

15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)
16. SOCIAL SECURITY NO.:
17. INFORMANT & ADDRESS: Hospital Record

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Acute glomerulonephritis — Interval Between Onset And Death: 7 days

DUE TO

Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. (b)

DUE TO

(c)

11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE (Specify)
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURED While at Work ☐ Not While At Work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 9-13, 1954, to 9-19, 1954, that I last saw the deceased alive on 9-19, 1954, and that death occurred at 3:25 A.M., from the causes and on the date stated above.

SIGNATURE (Degree or title) Willem R. Ellis Jr. MD
ADDRESS Salisbury, Md.
DATE SIGNED 9-19-54

23. BURIAL, CREMATION, REMOVAL (Specify) Removal
DATE THEREOF Sept 21. 1954
NAME OF CEMETERY OR CREMATORY Anatomical Bd.
LOCATION (City, town, or county) (State) Balto, Md.

DATE REC'D BY LOCAL REGISTRAR 9-20-54
REGISTRAR'S SIGNATURE Mary W. Holloway
24. FUNERAL DIRECTOR Barker M Wash
ADDRESS

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

Grk

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 08881

08860 **CERTIFICATE OF DEATH** Reg. Dist. No. 332

1. PLACE OF DEATH:
COUNTY Wicomico MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Salisbury
LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS Peninsula General Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland COUNTY Wicomico
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Salisbury
STREET ADDRESS (If rural give location) 412 Camden Ave.

3. NAME OF DECEASED: (Type or Print) (First) Dr. Hunter (Middle) Reece (Last) Mann. S.R.
4. DATE OF DEATH: (Month) (Day) (Year) September 7 1954.

5. SEX: Male
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):
8. DATE OF BIRTH: Apr. 19, 1889
9. AGE last birthday: 65 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION. Give kind of work done during most of working life, even if retired: Doctor
10b. KIND OF BUSINESS OR INDUSTRY: Physician
11. BIRTHPLACE (State or foreign country): Virginia
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: John Mann
14. MOTHER'S MAIDEN NAME: Josephine Carter

15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)
16. SOCIAL SECURITY No.:
17. INFORMANT & ADDRESS: Mrs. H. R. Mann, Sr. Salisbury Md

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Myocardial infarct, acute — Interval Between Onset And Death: 3 hours

DUE TO

Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. (b) Arteriosclerotic coronary thrombosis — unknown

DUE TO

(c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE (Specify)
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURED While at Work ☐ Not While At Work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from ....., 19...., to ....., 19....., that I last saw the deceased alive on 9-7, 1954, and that death occurred at 5:50 PM, from the causes and on the date stated above.

SIGNATURE (Degree or title) Willan R. Ellis, J. MD
ADDRESS Salisbury Md.
DATE SIGNED 9-7-54

23. BURIAL, CREMATION, REMOVAL (Specify)
DATE THEREOF 9-9-54
NAME OF CEMETERY OR CREMATORY Maplewood Cemetery
LOCATION (City, town, or county) (State) Charlottesville, Va.

DATE REC'D BY LOCAL REGISTRAR 9-8-54
REGISTRAR'S SIGNATURE Mary W. Holloway
24. FUNERAL DIRECTOR The Hill & Johnson Co. Salisbury, Md.
ADDRESS George C. Hill

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
SEP 10 1954
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08889

CERTIFICATE OF DEATH

08882

Reg. Dist. No. 332

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH:
COUNTY: Wicomico — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Clara
LENGTH OF STAY (in this place): 70 Yrs.
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Clara

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE: Maryland — COUNTY: Wicomico
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Clara
STREET ADDRESS (If rural give location): Clara

3. NAME OF DECEASED: (First) PAUL (Middle) DENNIS (Last) MEZICK

4. DATE OF DEATH: (Month) 9 (Day) 25 (Year) 19 54

5. SEX: Male

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Widowed

8. DATE OF BIRTH: May 7, 1884

9. AGE last birthday: 70 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired): Retired Merchant

10b. KIND OF BUSINESS OR INDUSTRY: Own Store

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME: John C. Mezick

14. MOTHER'S MAIDEN NAME: Ester Davis

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No — (If Yes, give war or dates of service) ---

16. SOCIAL SECURITY No.: None

17. INFORMANT & ADDRESS: Mrs. Edward G. Bounds, Salisbury

18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Coronary Thrombosis

DUE TO (b) Coronary Atherosclerosis

Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. DUE TO (c)

Interval Between Onset And Death: about 3 hrs Symptoms 2 yrs

11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death: Myocardial Insufficiency Coronary Artery Heart Disease

19a. DATE OF OPERATION: — **19b. MAJOR FINDINGS OF OPERATION:**

20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) — **PLACE OF INJURY** (Home, farm, factory, street, office bldg., etc.) — (CITY OR TOWN) — (COUNTY) — (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. — INJURY OCCURED While at Work ☐ Not While At Work ☐ — HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from March 21, 1954, to Sept. 28, 1954, that I last saw the deceased alive on Sept. 27, 1954, and that death occurred at 7:30 A., from the causes and on the date stated above.

SIGNATURE (Degree or title): David J. Gilmore M.D. — ADDRESS: Salisbury Md. — DATE SIGNED: Sept. 29 1954

23. BURIAL, CREMATION, REMOVAL (Specify): Burial — **DATE THEREOF:** 9/30/54 — **NAME OF CEMETERY OR CREMATORY:** Parsons Cemtery — **LOCATION** (City, town, or county) (State): Salisbury, Maryland

DATE REC'D BY LOCAL REGISTRAR: 9/30/54 — **REGISTRAR'S SIGNATURE:** Mary W. Holloway

24. FUNERAL DIRECTOR: The Hill & Johnson Co. — **ADDRESS:** Salisbury Md.

George C. Hill II

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 08883

08861 # CERTIFICATE OF DEATH Reg. Dist. No. 332

1. PLACE OF DEATH:
COUNTY Wicomico MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Salisbury 12
LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS Peninsula General Hosp.

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland COUNTY Worcester
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Pocomoke
STREET ADDRESS (If rural give location) Rt #2

3. NAME OF DECEASED: (First) (Middle) (Last) Milbourne
4. DATE OF DEATH: (Month) 9 (Day) 2 (Year) 1954
5. SEX: Male
6. COLOR OR RACE: Negro
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):
8. DATE OF BIRTH: 9-2-54
9. AGE last birthday: yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min. 22
10a. USUAL OCCUPATION. Give kind of work done during most of working life, even if retired):
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME:
14. MOTHER'S MAIDEN NAME: Doris Alverta Milbourn
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of)
16. SOCIAL SECURITY NO.:
17. INFORMANT & ADDRESS:

18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Prematurity — Interval Between Onset And Death: 1 hr

DUE TO

Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last.

(b) Unknown

DUE TO

(c) Unknown

11. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify)
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURED While at Work ☐ Not While At Work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from ....,19.., to ....,19....., that I last saw the deceased alive on ....,19....., and that death occurred at 1:32 A.M., from the causes and on the date stated above.

SIGNATURE (Degree or title) Laura M. Bradford, MD ADDRESS Pocomoke DATE SIGNED 9/5/54

23. BURIAL, CREMATION, REMOVAL (Specify) DATE THEREOF 9-3-54 NAME OF CEMETERY OR CREMATORY Peninsula General Hospital LOCATION (City, town, or county) Salisbury (State) Wicomico Md.

DATE REC'D BY LOCAL REGISTRAR 9-3-54 REGISTRAR'S SIGNATURE Mary M. Holloway
24. FUNERAL DIRECTOR Peninsula General Hospital ADDRESS

9V9499V99V

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

SEP
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08890

CERTIFICATE OF DEATH

08884

Reg. Dist. No. 332

Item 7, FilmG170A 9-28-54 et

1. PLACE OF DEATH:
COUNTY Wicomico MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Salisbury
LENGTH OF STAY (in this place) 3 weeks
HOSPITAL OR INSTITUTION OR STREET ADDRESS Deerhead St. Hosp.

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE MD COUNTY Queen Anne
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Millington
STREET ADDRESS (If rural, give location) —

3. NAME OF DECEASED: (Type or Print) (First) ALFRED (Middle) MORRIS (Last)

4. DATE OF DEATH: (Month) 9 (Day) 18 (Year) 1954

5. SEX: M
6. COLOR OR RACE: W
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Unknown
8. DATE OF BIRTH: 8-31-72
9. AGE last birthday: 82 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): MD
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: —
14. MOTHER'S MAIDEN NAME: —

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) Unk (If Yes, give war or dates of service)
16. SOCIAL SECURITY NO.: —
17. INFORMANT & ADDRESS: Hospital Records

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH: — INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Coronary arteritis due to
DUE TO
Antecedent cause(s) (b) arteriosclerosis ?
Diseases or conditions, if any, giving rise to the above cause stating underlying cause last
DUE TO
(c)

II. OTHER SIGNIFICANT CONDITIONS: Conditions contributing to the death but not related to the disease or condition causing death. Hypertensive vascular disease ?

19a. DATE OF OPERATION: 19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify) PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) M. INJURY OCCURRED While at work ☐ Not while at work ☐ HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 8-30, 1954, to 9-18, 1954 that I last saw the deceased alive on 9-18, 1954 and that death occurred at 11 P.m., from the causes and on the date stated above.

SIGNATURE [signature] (DEGREE OR TITLE) ADDRESS Deerhead St Hospital DATE SIGNED 9-19-54

23. BURIAL, CREMATION REMOVAL (Specify): Removal DATE THEREOF Sept. 21, 1954 NAME OF CEMETERY OR CREMATORY Anatomical Bd LOCATION (City, town, or county) Balto. (State) Md

DATE REC'D BY LOCAL REG. 9-21-54 REGISTRAR'S SIGNATURE Mary W. Holloway 24. FUNERAL DIRECTOR Booker M Welsh ADDRESS

VS. A15 8-51

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
SEP
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 08885

08862

CERTIFICATE OF DEATH

Reg. Dist. No. 332

1. PLACE OF DEATH:
COUNTY Wicomico MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury
LENGTH OF STAY (in this place) Most of life
HOSPITAL OR INSTITUTION OR STREET ADDRESS At home - Route # 1

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland COUNTY Wicomico
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury, Route # 1
STREET ADDRESS (If rural give location)

3. NAME OF DECEASED: (Type or Print) (First) Arthur (Middle) (Last) Nairne

4. DATE OF DEATH: (Month) 9 - (Day) 10 - (Year) 1954

5. SEX: Male
6. COLOR OR RACE: A.A.
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married
8. DATE OF BIRTH: 7-12-1880
9. AGE last birthday: 74 yrs. IF UNDER 1 YEAR Months 1 Days 28 IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION. Give kind of work done during most of working life, even if retired): Laborer
10b. KIND OF BUSINESS OR INDUSTRY: Farming
11. BIRTHPLACE (State or foreign country): Salisbury, Wicomico Co., Md.
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Isaac Nairne
14. MOTHER'S MAIDEN NAME: Mary Fooks

15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No (If Yes, give war or dates of service) No
16. SOCIAL SECURITY No.: None
17. INFORMANT & ADDRESS: Mrs. Ida Mae Nairne, Salisbury, Md., Rt. # 1

18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Cerebral hemorrhage
DUE TO

Antecedent causes(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. (b)
DUE TO
(c)

Interval Between Onset And Death 5 yrs.

11. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify)
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURED While at Work ☐ Not While At Work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from July 2, 1954 to Sept 10, 1954 that I last saw the deceased alive on Sept 10, 1954 and that death occurred at 9:15 AM from the causes and on the date stated above.

SIGNATURE Carl M. Beardsley (Degree or title) M.D. ADDRESS Pittsville Md DATE SIGNED 9/13/54

23. BURIAL, CREMATION, REMOVAL (Specify) Burial
DATE THEREOF 9-13-'54
NAME OF CEMETERY OR CREMATORY Mt. Calvary Cemetery
LOCATION (City, town, or county) (State) Fruitland, Wicomico Co., Md.

DATE REC'D BY LOCAL REGISTRAR 9-13-54
REGISTRAR'S SIGNATURE Mary W. Holloway

24. FUNERAL DIRECTOR Mary A. Stewart, ADDRESS 324 E. Church St. Salisbury, Maryland

STEWART FUNERAL HOME

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

I

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08863

CERTIFICATE OF DEATH

08886

Reg. Dist. No. 332

1. PLACE OF DEATH:

COUNTY Wicomico — MARYLAND

CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Salisbury

LENGTH OF STAY (in this place)

HOSPITAL OR INSTITUTION OR STREET ADDRESS Peninsula General Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE Maryland — COUNTY Wicomico

CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Salisbury

STREET ADDRESS (If rural give location) 226 N. Division Street.

3. NAME OF DECEASED: (Type or Print) (First) Helen (Middle) (Last) Swan.

4. DATE OF DEATH: (Month) September (Day) 28 (Year) 1954

5. SEX: Female

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):

8. DATE OF BIRTH: 1909

9. AGE last birthday: 45 yrs. IF UNDER 1 YEAR: Months / Days. IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION. Give kind of work done during most of working life, even if retired): Registered nurse.

10b. KIND OF BUSINESS OR INDUSTRY: Nursing

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: James W. Stack

14. MOTHER'S MAIDEN NAME: Fannie May Skinner

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)

16. SOCIAL SECURITY No.: 220-18-3839

17. INFORMANT & ADDRESS: Blanche S. Hirs St Michaels, Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

40 y.

Immediate cause (a) R. lower lobe, lobar pneumonia — Interval Between Onset And Death: 24 hours.

DUE TO

Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last.

(b) Acute alcoholism — Years.

DUE TO

(c)

11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: **19b. MAJOR FINDINGS OF OPERATION** **20. AUTOPSY?** Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) — **PLACE OF INJURY** (Home, farm, factory, street, office bldg., etc.) — (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. — INJURY OCCURED While at Work ☐ Not While At Work ☐ — HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 9/26, 1954, to 9/28, 1954, that I last saw the deceased alive on 9/28, 1954, and that death occurred at 8:40 A.M., from the causes and on the date stated above.

SIGNATURE (Degree or title) M.D. — ADDRESS Salisbury, Md. — DATE SIGNED 9/28/54

23. BURIAL, CREMATION, REMOVAL (Specify) — DATE THEREOF 9/30/54 — NAME OF CEMETERY OR CREMATORY Crumpton — LOCATION (City, town, or county) Crumpton (State) Md.

DATE REC'D BY LOCAL REGISTRAR 9-28-54 — REGISTRAR'S SIGNATURE Mary M. Holloway

24. FUNERAL DIRECTOR Edgar S. Lee — ADDRESS Church Hill Md.

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

MARGIN RESERVED FOR BINDING

RECEIVED
SEP 30 1954
BUREAU V

08891

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08887

CERTIFICATE OF DEATH

Reg. Dist. No. 332

Item 9, FilmG170A 9-29-54 et

1. PLACE OF DEATH:

COUNTY Wicomico — MARYLAND

CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Salisbury X — LENGTH OF STAY (in this place) 4 days

HOSPITAL OR INSTITUTION OR STREET ADDRESS Deer's Head State Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE Md — COUNTY Worcester

CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Pocomoke — 2-4 [illegible]

STREET ADDRESS (If rural, give location) Virginia Road

3. NAME OF DECEASED: (Type or Print) (First) DAVID (Middle) (Last) PICKHARDT.

4. DATE OF DEATH: (Month) Sept (Day) 19 (Year) 1954

5. SEX: M

6. COLOR OR RACE: W

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Single

8. DATE OF BIRTH: 11-17-1885

9. AGE last birthday: 68 69 yrs. — IF UNDER 1 YEAR: Months, Days — IF UNDER 24 HRS.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farm owner

10b. KIND OF BUSINESS OR INDUSTRY: Farming

11. BIRTHPLACE (State or foreign country): Conn.

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Pickhardt, Gustavus

14. MOTHER'S MAIDEN NAME: Schneider, Louisa

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No — (If Yes, give war or dates of service) None

16. SOCIAL SECURITY NO.: None

17. INFORMANT & ADDRESS: Cora M. Pickhardt, Pocomoke, Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) cardiac decompensation due to	4 days
Antecedent cause(s) — Diseases or conditions, if any, giving rise to the above cause stating underlying cause last	DUE TO (b) myocardial degeneration assoc.	
	DUE TO (c) Progressive muscular Dystrophy	years.

II. OTHER SIGNIFICANT CONDITIONS: Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify) — PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) — (CITY OR TOWN) — (COUNTY) — (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) M. — INJURY OCCURRED While at work ☐ Not while at work ☐ — HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 9-14, 1954, to 9-19, 1954, that I last saw the deceased alive on 9-19, 1954, and that death occurred at 9:50 A.m., from the causes and on the date stated above.

SIGNATURE [signature] — (DEGREE OR TITLE) ADDRESS Deerhead State Hosp — DATE SIGNED 9-19-54

23. BURIAL, CREMATION REMOVAL (Specify): Burial — DATE THEREOF 9-24-54 — NAME OF CEMETERY OR CREMATORY Presbyterian Cemetery — LOCATION (City, town, or county) Pocomoke, Md. (State)

DATE REC'D BY LOCAL REG. 9-22-54 — REGISTRAR'S SIGNATURE Mary W. Holloway — **24. FUNERAL DIRECTOR** Henry L. Watson, Pocomoke Md. — ADDRESS

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15 8-51

RECEIVED
SEP 1954
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 08888

CERTIFICATE OF DEATH

08864

Reg. Dist. No. 332

1. PLACE OF DEATH:
COUNTY Wicomico MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Salisbury 12
LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS Peninsula General Hospital 70

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland COUNTY
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Mt Vernon
STREET ADDRESS (If rural give location)

3. NAME OF DECEASED: (Type or Print) (First) Strangley (Middle) (Last) Pritchett

4. DATE OF DEATH: (Month) September (Day) 6 (Year) 1954

5. SEX: Male
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):
8. DATE OF BIRTH: May 10, 1873
9. AGE last birthday: 81 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION. Give kind of work done during most of working life, even if retired: Retired Waterman
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Mt Vernon, Md
12. CITIZEN OF WHAT COUNTRY: USA

13. FATHER'S NAME: Robert Lee Pritchett
14. MOTHER'S MAIDEN NAME: Pauline Webster

15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No (If Yes, give war or dates of service)
16. SOCIAL SECURITY No.:
17. INFORMANT & ADDRESS: Mr. John Pritchett, Mt. Vernon, Md.

18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Cerebral Hemorrhage (Left Side)
DUE TO

Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. (b) Arteriosclerosis.
DUE TO
(c)

Interval Between Onset And Death

11. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE (Specify)
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURED While at Work ☐ Not While At Work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Aug. 1st, 1954, to September 6 1954, that I last saw the deceased alive on Sept 6, 1954, and that death occurred at 1:35 pm, from the causes and on the date stated above.

SIGNATURE Carrie I Hearn (Degree or title) M.D. ADDRESS 11 S W Church St DATE SIGNED 9/7/54

23. BURIAL, CREMATION, REMOVAL (Specify) DATE THEREOF 9-8-54 NAME OF CEMETERY OR CREMATORY Grace Episcopal Cemetery LOCATION (City, town, or county) Mt. Vernon, Md. (State)

DATE REC'D BY LOCAL REGISTRAR 9-8-54 REGISTRAR'S SIGNATURE Mary W. Holloway
24. FUNERAL DIRECTOR Dashiell Funeral Home, Princess Anne, Md ADDRESS
Per. M W H.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
SEP 10 1954
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 08889

08865

CERTIFICATE OF DEATH

Reg. Dist. No. 332

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH:
COUNTY Wicomico
CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN Salisbury
MARYLAND
LENGTH OF STAY (in this place) 1 Hour
HOSPITAL OR INSTITUTION OR STREET ADDRESS Peninsula General Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Md COUNTY Worcester
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Snow Hill
STREET ADDRESS (If rural give location)

3. NAME OF DECEASED: (Type or Print) (First) Elizabeth (Middle) S. (Last) Pusey

4. DATE OF DEATH: (Month) September (Day) 19 (Year) 1954

5. SEX: Female
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Widowed
8. DATE OF BIRTH: June 10 1875
9. AGE last birthday: 79 yrs. 3 9
IF UNDER 1 YEAR: Months Days
IF UNDER 24 HRS.: Hours Min.

10a. USUAL OCCUPATION. Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY: Own Home
11. BIRTHPLACE (State or foreign country): Frankford, Delaware
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Absom Walls
14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No
(If Yes, give war or dates of service)
16. SOCIAL SECURITY NO.: None
17. INFORMANT & ADDRESS: Mr. G. Weston Pusey, Snow Hill Md

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Myocardial Infarct, acute — Interval Between Onset And Death: 1 hour
DUE TO

Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last.
(b)
DUE TO
(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURED While at Work ☐ Not While At Work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from ..... ,19..... , to ...., 19....., that I last saw the deceased alive on 9-19 , 1954, and that death occurred at 5 P.M., from the causes and on the date stated above.

SIGNATURE (Degree or Title) William B. Ellis, Jr. MD
ADDRESS Salisbury, Md.
DATE SIGNED 9-19-54

23. BURIAL, CREMATION, REMOVAL (Specify) Burial
DATE THEREOF Sept. 22/54
NAME OF CEMETERY OR CREMATORY Christian
LOCATION (City, town, or county) (State) Snow Hill, Md

DATE REC'D BY LOCAL REGISTRAR 9-21-54
REGISTRAR'S SIGNATURE Mary M. Holloway
24. FUNERAL DIRECTOR Ulay E. Dennis
ADDRESS Snow Hill Md.

SEP
BUREAU OF

08892 08890

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 Reg. Dist.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH No. 332

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15A - 5 - 53

1. PLACE OF DEATH:
COUNTY Wicomico — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Fruitland
LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Md. COUNTY Wicomico
CITY (If outside corporate limits write RURAL and give nearest town) OR TOWN Fruitland
STREET ADDRESS (If rural, give location) St. Luke Road

3. NAME OF DECEASED: (First) Julius (Middle) David (Last) Reynor

4. DATE OF DEATH (Month) Sept (Day) 20 (Year) 19 54

5. SEX: Male

6. COLOR OR RACE: Colored

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Single

8. DATE OF BIRTH: July 10, 1954

9. AGE Last birthday: yrs. — IF UNDER 1 YEAR: Months 2 Days 10 — IF UNDER 24 HRS.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): None

10b. KIND OF BUSINESS OR INDUSTRY: None

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Julius Reynor

14. MOTHER'S MAIDEN NAME: Alice Smith

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)

16. SOCIAL SECURITY NO.:

17. INFORMANT & ADDRESS: Julius Reynor Fruitland, Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH: — INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Upper respiratory infection

DUE TO

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating underlying cause last (b)

DUE TO

(c)

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

19a. DATE OF OPERATION: **19b. MAJOR FINDING OF OPERATION:** **20. AUTOPSY?** Yes ☐ No ☑

21a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY

21c. (City or town) (County) (State)

21d. TIME (Month) (Day) (Year) (Hour) OF INJURY M.

21e. INJURY OCCURRED While at work ☐ Not while at work ☐

21f. HOW DID INJURY OCCUR?

22. I hereby certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☑, Inquiry ☑, and find that death resulted from: Natural causes ☑, Accident ☐, Suicide ☐, Homicide ☐, Undetermined cause ☐.

SIGNATURE Emil L Reynor M. D. CHIEF MEDICAL EXAMINER ☐ DEPUTY MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAM. ☑ DATE SIGNED 9-20-54

23. BURIAL, CREMATION, REMOVAL (Specify): Burial — DATE THEREOF Sept. 23, 1954 — NAME OF CEMETERY OR CREMATORY West Post Office — LOCATION (City, town, or county) West Post Office, Somerset Co. (State)

DATE REC'D BY LOCAL REG. 9-21-54 — REGISTRAR'S SIGNATURE Mary M. Holloway

24. FUNERAL DIRECTOR Booker W. West — ADDRESS

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08891

08866 CERTIFICATE OF DEATH

Reg. Dist. No. 332

1. PLACE OF DEATH:

COUNTY Wicomico MARYLAND

CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Salisbury 12

LENGTH OF STAY (in this place)

HOSPITAL OR INSTITUTION OR STREET ADDRESS Peninsula General Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE Maryland COUNTY Wicomico

CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Sharptown

STREET ADDRESS (If rural give location)

3. NAME OF DECEASED: (Type or Print) (First) Robert (Middle) LANCE (Last) Russell

4. DATE OF DEATH: (Month) (Day) (Year) September 5 1954

5. SEX: Male

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):

8. DATE OF BIRTH: Mar 14, 1890

9. AGE last birthday: 64 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION. Give kind of work done during most of working life even if retired: Painter (Retired)

10b. KIND OF BUSINESS OR INDUSTRY: WOWE

11. BIRTHPLACE (State or foreign country): MD

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Thomas J Russell

14. MOTHER'S MAIDEN NAME: Olivia Ellen Dennis

15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) NO (If Yes, give war or dates of service)

16. SOCIAL SECURITY No.: 218-14-7656

17. INFORMANT & ADDRESS: Mr. Robert Russell, Berlin, md

18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

331X

Immediate cause (a) Cerebral Hemorrhage — Interval Between Onset And Death: 1 day

DUE TO

Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. (b) Cerebral Atherosclerosis — Symptoms 9 yrs

DUE TO

(c) Hypertension, essential (severe — " "

11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Myocardial Insufficiency

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify)

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURED While at Work ☐ Not While At Work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from ....., 19....., to ....., 19....., that I last saw the deceased alive on 9/5, 1954, and that death occurred at 3:05 pm, from the causes and on the date stated above.

SIGNATURE (Degree or title) David J. Gilmore M.D. ADDRESS Salisbury Md. DATE SIGNED Sept. 5 1954

23. BURIAL, CREMATION, REMOVAL (Specify) Burial

DATE THEREOF 9/8/54

NAME OF CEMETERY OR CREMATORY Taylor Cemetery

LOCATION (City, town, or county) (State) Sharptown - md

DATE REC'D BY LOCAL REGISTRAR 9-9-54

REGISTRAR'S SIGNATURE Mary W. Holloway

24. FUNERAL DIRECTOR Paul J. Smith ADDRESS Sharptown, md

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

SEP 9 1954
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 08892

08893

CERTIFICATE OF DEATH

Reg. Dist. No. 232

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15 8-51

1. PLACE OF DEATH:

COUNTY Wicomico — MARYLAND

CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN Salisbury

LENGTH OF STAY (in this place) 30 days

HOSPITAL OR INSTITUTION OR STREET ADDRESS Deer's Head State Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE Md COUNTY Somerset

CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Allen

STREET ADDRESS (If rural, give location)

1

3. NAME OF DECEASED: (Type or Print) (First) Beatrice (Middle) Pearl (Last) Sapp.

4. DATE OF DEATH: (Month) Sept. (Day) 5 (Year) 1954

5. SEX: F.

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married

8. DATE OF BIRTH: Febr. 1st 1907

9. AGE last birthday: 47 yrs. IF UNDER 1 YEAR Months IF UNDER 24 HRS. Days Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: own home.

11. BIRTHPLACE (State or foreign country): Willards, Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: William Cooper

14. MOTHER'S MAIDEN NAME: Elizabeth Littleton.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) ✓ (If Yes, give war or dates of service) ✓

16. SOCIAL SECURITY NO.: 222-090-642

17. INFORMANT & ADDRESS: Deer's Head Hospital records

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

Immediate cause (a) Hypernephroma c. advanced metastases — INTERVAL BETWEEN ONSET AND DEATH 8-9 mo.

DUE TO

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating underlying cause last (b) to chest and pelvis

DUE TO

(c)

II. OTHER SIGNIFICANT CONDITIONS: Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: 19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify) PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) M. INJURY OCCURRED While at work ☐ Not while at work ☐ HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 8/9, 1954, to 9/5, 1954, that I last saw the deceased alive on 9/5, 1954, and that death occurred at 5:20 p.m., from the causes and on the date stated above.

SIGNATURE M. V. Sherman (DEGREE OR TITLE) MD ADDRESS Deer's Head Hospital Salisbury Md DATE SIGNED 9/5/54

23. BURIAL, CREMATION REMOVAL (Specify): Burial — DATE THEREOF Sept 8, 1954 — NAME OF CEMETERY OR CREMATORY Barnetts Chapel — LOCATION (City, town, or county) (State) Fredericka, Del.

DATE REC'D BY LOCAL REG. 9-8-54 — REGISTRAR'S SIGNATURE Mary W. Holloway

24. FUNERAL DIRECTOR Peter Whaley ADDRESS Selbyville Del.

RECEIVED
SEP 10 1954
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Dr. Insley 08867

CERTIFICATE OF DEATH

Reg. Dist. No. 08893 332

Item 2, FilmG170A 9-24-54 et

1. PLACE OF DEATH:
COUNTY Wicomico MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury
LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS John B. Parsons Home(Lemon Hill)

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland COUNTY Wicomico
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ~~Salisbury~~ Pocomoke, 23423
STREET ADDRESS (If rural give location) Unknown ~~John B. Parsons Home(Lemon Hill)~~

3. NAME OF DECEASED: (Type or Print) (First) LULU (Middle) KING (Last) SCOTT

4. DATE OF DEATH: (Month) SEPT (Day) 17 (Year) 19 54

5. SEX: Female
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Widowed
8. DATE OF BIRTH: Sept. 5, 1872
9. AGE last birthday: 82 yrs. IF UNDER 1 YEAR Months 0 Days 12 IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION. Give kind of work done during most of working life, even if retired: Retired House Keeper
10b. KIND OF BUSINESS OR INDUSTRY: House Work at Home
11. BIRTHPLACE (State or foreign country): Pocomoke, Maryland
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Jacob E. Stevenson
14. MOTHER'S MAIDEN NAME: Ann Grace Young

15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No (If Yes, give war or dates of service)
16. SOCIAL SECURITY No.:
17. INFORMANT & ADDRESS: Records(John B. Parsons Home) Salisbury, Md.

18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Cardio vascular renal disease
DUE TO

Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. (b)
DUE TO
(c)

Interval Between Onset And Death

11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death: Metastatic carcinoma chest wall

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE (Specify)
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURED While at Work ☐ Not While At Work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from March 1954, to Sept 17, 1954, that I last saw the deceased alive on Sept 16 1954 and that death occurred at 9:15 P.M., from the causes and on the date stated above.

SIGNATURE (Degree or title) Philip A Insley MD
ADDRESS Main St. Salisbury, Maryland
DATE SIGNED Sept. 1954

23. BURIAL, CREMATION, REMOVAL (Specify) Burial
DATE THEREOF Sept.19,1954
NAME OF CEMETERY OR CREMATORY Bethany Meth. Cemetery
LOCATION (City, town, or county) (State) Pocomoke, Maryland

DATE REC'D BY LOCAL REGISTRAR 9-19-54
REGISTRAR'S SIGNATURE Mary W. Holloway

24. FUNERAL DIRECTOR HOLLOWAY & COMPANY SALISBURY MARYLAND
ADDRESS

Walter R. Holloway

Walter R. Holloway

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
SEP 21 19
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 08894

CERTIFICATE OF DEATH

08894

Reg. Dist. No. 332

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15 8-54

1. PLACE OF DEATH:

COUNTY Wicomico — MARYLAND

CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN Salisbury,

LENGTH OF STAY (in this place) 1 yr. 3 mos.

HOSPITAL OR INSTITUTION OR STREET ADDRESS Deer's Head State

2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE Maryland COUNTY Washington

CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Hagerstown

STREET ADDRESS (If rural, give location) Medway Road

3. NAME OF DECEASED: (Type or Print)	(First)	(Middle)	(Last)	4. DATE OF DEATH: (Month) (Day) (Year)
	George	W.	Shives	September 9, 19 54

5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH:	9. AGE last birthday:	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
M	W	Widowed	3/16/1878	76 yrs.				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):	10b. KIND OF BUSINESS OR INDUSTRY:	11. BIRTHPLACE (State or foreign country):	12. CITIZEN OF WHAT COUNTRY?
Laborer	Unk,	Hancock	U.S.A.

13. FATHER'S NAME:	14. MOTHER'S MAIDEN NAME:
Daniel H. Shives	Clara B. Kline

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)	16. SOCIAL SECURITY NO.:	17. INFORMANT & ADDRESS:
Unk Unk.	215-07-5269	Hospital Records

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Cerebral thrombosis, recurrent	18 h.
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating underlying cause last	(b) Arteriosclerosis	?
	(c)	

II. OTHER SIGNIFICANT CONDITIONS: Conditions contributing to the death but not related to the disease or condition causing death. Arteriosclerotic cardiovascular disease a. glomerulonephritis. Diabetes mellitus ?

19a. DATE OF OPERATION:	19b. MAJOR FINDINGS OF OPERATION:	20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at work ☐ Not while at work ☐	HOW DID INJURY OCCUR?
M.		

22. I hereby certify that I attended the deceased from 5.25, 1954, to 9.9., 1954, that I last saw the deceased alive on 9.9., 1954, and that death occurred at 5.05 A.m., from the causes and on the date stated above.

SIGNATURE	(DEGREE OR TITLE)	ADDRESS	DATE SIGNED
H. V. Sherman	M.D.	Deer's Head State Hospital, Salisbury Md	9.9.54

23. BURIAL, CREMATION REMOVAL (Specify):	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	9-12-54	Shives Cemetery	Hancock Washington Md

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
9-11-54	Mary W. Holloway	Howard J. Stone	Hancock, Md

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 08895

Dr. Burton 08868

CERTIFICATE OF DEATH

Reg. Dist. No. 332

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH:
COUNTY: Wicomico — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Salisbury
LENGTH OF STAY (in this place): 24
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Pen. Gen. Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE: Maryland — COUNTY: Wicomico
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Salisbury
STREET ADDRESS (If rural give location): 632 Liberty St.

3. NAME OF DECEASED: (Type or Print) (First) LEWIS (Middle) MC CULLEN (Last) TAYLOR

4. DATE OF DEATH: (Month) SEPT. (Day) 18 (Year) 19 54

5. SEX: Male

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Widowed

8. DATE OF BIRTH: May 6, 1865

9. AGE last birthday: 89 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired Waterman

10b. KIND OF BUSINESS OR INDUSTRY: Worked on Boats

11. BIRTHPLACE (State or foreign country): Siloam Maryland

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: No Record

14. MOTHER'S MAIDEN NAME: No Record

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) Unk (If Yes, give war or dates of service)

16. SOCIAL SECURITY NO.:

17. INFORMANT & ADDRESS: Mrs. Georgia M. Lewis (Daughter) 632 Liberty St. Salisbury, Maryland

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause — (a) Right cerebral thrombosis — Interval Between Onset And Death: 7 days

DUE TO

Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. — (b) Senile arteriosclerosis — Years

DUE TO

(c)

11. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: — 19b. MAJOR FINDINGS OF OPERATION — 20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) — PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) — (CITY OR TOWN) — (COUNTY) — (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. — INJURY OCCURED While at Work ☐ Not While At Work ☐ — HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 9/11/54, to 9/18/54, that I last saw the deceased alive on 9/18/54, and that death occurred at 1:00 P.M., from the causes and on the date stated above.

SIGNATURE: [signature] L. D. (Degree or title) — ADDRESS: Broad & Church Sts. Salisbury, Maryland — DATE SIGNED: Sept. 18 1954

23. BURIAL, CREMATION, REMOVAL (Specify): Burial — DATE THEREOF: Sept. 20, 1954 — NAME OF CEMETERY OR CREMATORY: Tyaskin Esp. Cemetery — LOCATION (City, town, or county) (State): Tyaskin, Maryland

DATE REC'D BY LOCAL REGISTRAR: 9-20-54 — REGISTRAR'S SIGNATURE: Mary W. Holloway

24. FUNERAL DIRECTOR: HOLLOWAY & COMPANY — ADDRESS: SALISBURY MARYLAND

Walter R. Holloway — Walter R. Holloway

RECEIVED
SEP 22 1954
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08869 08896

CERTIFICATE OF DEATH

Reg. Dist. No. 332

1. PLACE OF DEATH:
COUNTY Wicomico MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Salisbury
LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS Peninsula General Hosp.

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Virginia COUNTY
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Horntown
STREET ADDRESS (If rural give location)

3. NAME OF DECEASED: (Type or Print) (First) Justine (Middle) (Last) Townsend

4. DATE OF DEATH: (Month) 9 - (Day) 10 (Year) 1954

5. SEX: Female
6. COLOR OR RACE: Negro
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Single
8. DATE OF BIRTH: 8-27-54
9. AGE last birthday: yrs. IF UNDER 1 YEAR Months Days 15 IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired):
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Va
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Orville Townsend
14. MOTHER'S MAIDEN NAME: Heline Cropper

15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)
16. SOCIAL SECURITY No.:
17. INFORMANT & ADDRESS: Orville Townsend Horntown, Va

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) ① Subdural Hematoma, acute — Interval Between Onset And Death: 3 days

DUE TO ② Inadequate fluid intake and diarrhea with

Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. (b) Dehydration and acidosis, severe — 3 days

DUE TO (c) Monilial Stomatitis, severe. — 1 week

11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: none
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE (Specify) none
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) none (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURED While at Work ☐ Not While At Work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Sept 8, 1954, to Sept 10, 1954, that I last saw the deceased alive on Sept 10, 1954, and that death occurred at 10 P.M. Sept 10, 1954 from the causes and on the date stated above.

SIGNATURE (Degree or title) Robert H. Gunderson Jr. M.D.
ADDRESS 926 N. Division St, Salisbury
DATE SIGNED 9/11/54

23. BURIAL, CREMATION, REMOVAL (Specify) Burial
DATE THEREOF 9/11/54
NAME OF CEMETERY OR CREMATORY Horntown Cem
LOCATION (City, town, or county) Horntown, Va (State)

DATE REC'D BY LOCAL REGISTRAR 9-11-54
REGISTRAR'S SIGNATURE Mary W. Holloway
24. FUNERAL DIRECTOR Edgar Wharton
ADDRESS New Church, Va

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 08897

08870

CERTIFICATE OF DEATH

Reg. Dist. No. 332

1. PLACE OF DEATH:
COUNTY Wicomico MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Salisbury
LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS Peninsula General Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland COUNTY Wicomico
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Rockawalkin
STREET ADDRESS (If rural give location)

3. NAME OF DECEASED: (Type or Print) (First) Isaac (Middle) H (Last) Trader

4. DATE OF DEATH: (Month) September (Day) 10 (Year) 1954

5. SEX: Male
6. COLOR OR RACE: Colored
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):
8. DATE OF BIRTH: Dec 17 1893
9. AGE last birthday: 61 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farmer
10b. KIND OF BUSINESS OR INDUSTRY: None
11. BIRTHPLACE (State or foreign country): Parsonsburg, Md
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Wesley Trader
14. MOTHER'S MAIDEN NAME: Elizabeth Hammond

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) no (If Yes, give war or dates of service)
16. SOCIAL SECURITY No.: 220-12-1396
17. INFORMANT & ADDRESS: Clare Trader

18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

181X

Immediate cause (a) Generalized Carcinoma — Interval Between Onset And Death: months

Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last.

DUE TO (b) Carcinoma of Bladder — yr.

DUE TO (c)

11. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE (Specify)
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURED While at Work ☐ Not While At Work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Sept. 6, 1954, to Sept. 10, 1954, that I last saw the deceased alive on 10 Sept, 1957, and that death occurred at 2:38 pm, from the causes and on the date stated above.

SIGNATURE (Degree or title) Earl L Rogers MD — ADDRESS 407 Camden Ave — DATE SIGNED 9-12-54

23. BURIAL, CREMATION, REMOVAL (Specify)
DATE THEREOF 9-15-54
NAME OF CEMETERY OR CREMATORY Rockawalkin Cemetery
LOCATION (City, town, or county) Rockawalkin, Md (State)

DATE REC'D BY LOCAL REGISTRAR 9-14-54
REGISTRAR'S SIGNATURE Mary W. Holloway
24. FUNERAL DIRECTOR Booker M. West ADDRESS

Per: Dolores L. Hughes

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
SEP 1
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 — 08871 — 08898

CERTIFICATE OF DEATH

Item 7, FilmG170A 10-4-54-et

Reg. Dist. No. 332

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH:
COUNTY: Wicomico — MARYLAND
CITY (If outside corporate limits, write RURAL) OR TOWN and give nearest town): Salisbury
LENGTH OF STAY (in this place):
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Pen. Gen. Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE: Maryland — COUNTY: Wicomico
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Parsonsburg
STREET ADDRESS (If rural give location): R.D. #

3. NAME OF DECEASED: (Type or Print) (First) SIDNEY (Middle) HERMAN (Last) TRUITT

4. DATE OF DEATH: (Month) SEPT (Day) 27 (Year) 1954

5. SEX: Male

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Single

8. DATE OF BIRTH: Nov. 11, 1875

9. AGE last birthday: 78 yrs. — IF UNDER 1 YEAR: Months 10, Days 16 — IF UNDER 24 HRS.: Hours, Min.

10a. USUAL OCCUPATION. Give kind of work done during most of working life, even if retired: Retired Farmer

10b. KIND OF BUSINESS OR INDUSTRY: On Own Farm

11. BIRTHPLACE (State or foreign country): Pittsville, Maryland

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Thomas Truitt

14. MOTHER'S MAIDEN NAME: Sallie E. Brittingham

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) Unk (If Yes, give war or dates of service)

16. SOCIAL SECURITY No.:

17. INFORMANT & ADDRESS: Mr. King W. Workman R.D. # 3 Salisbury, Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause — (a) DUE TO: Congestive heart failure — Interval Between Onset And Death: 1yr.

Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. — (b) DUE TO: degenerative heart disease — 5yr.

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURED While at Work ☐ Not While At Work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 9 - 21, 1954, to 9 - 27, 1954, that I last saw the deceased alive on 9-26, 1954, and that death occurred at 7:00 A.M., from the causes and on the date stated above.

SIGNATURE (Degree or title): Carl W. Leudsley M.D. — ADDRESS: E. Church St. Salisbury, Maryland — DATE SIGNED: Sept 28 1954

23. BURIAL, CREMATION, REMOVAL (Specify): Burial — DATE THEREOF: Sept 29, 1954 — NAME OF CEMETERY OR CREMATORY: Pittsville, Cemetery — LOCATION (City, town, or county) (State): Pittsville, Maryland

DATE REC'D BY LOCAL REGISTRAR: 9-28-54 — REGISTRAR'S SIGNATURE: Mary W. Holloway

24. FUNERAL DIRECTOR — ADDRESS: HOLLOWAY & COMPANY SALISBURY MARYLAND

Walter R. Holloway

RECEIVED
SEP 30 1954
BUREAU V. S.

08899

08872

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 332

1. PLACE OF DEATH:
COUNTY Wicomico MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Salisbury
LENGTH OF STAY (in this place) 14 days
HOSPITAL OR INSTITUTION OR STREET ADDRESS Peninsula General Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland COUNTY Worcester
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Pocomoke
STREET ADDRESS (If rural give location) R.R. # 2

3. NAME OF DECEASED: (Type or Print) (First) Landonia (Middle) S. (Last) Tull

4. DATE OF DEATH: (Month) September (Day) 30 (Year) 1954

5. SEX: F
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Married
8. DATE OF BIRTH: July 31, 1882
9. AGE last birthday: 72 yrs. If under 1 year: Months Days; If under 24 hrs.: Hours Min.

10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired: Housewife
10b. KIND OF BUSINESS OR INDUSTRY: Own Home
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: William H. Sturgis
14. MOTHER'S MAIDEN NAME: Jeannette Pilchard

15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No (If Yes, give war or dates of service)
16. SOCIAL SECURITY No.: None
17. INFORMANT & ADDRESS: Calvin B. Tull, Pocomoke, Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — Interval Between Onset And Death

Immediate cause (a) Uremia: arteriosclerotic C.V. renal disease

Antecedent causes(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last.
DUE TO (b) Partial intestinal obstruction: pyelonephritis, left.
DUE TO (c) Hepatic insufficiency: auricular fibrillation. 2 wks.

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: 9-25-54
19b. MAJOR FINDINGS OF OPERATION: Partial intestinal obstruction
20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify)
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURED While at Work ☐ Not While At Work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 9-16-, 1954, to 9-30-, 1954, that I last saw the deceased alive on 9-29-, 1954, and that death occurred at 6 A.M., from the causes and on the date stated above.
SIGNATURE (Degree or title) William H. Fishman Jr. ADDRESS Salisbury, Md. DATE SIGNED 9-30-54

23. BURIAL, CREMATION, REMOVAL (Specify)
DATE THEREOF 10-3-54
NAME OF CEMETERY OR CREMATORY Salem M.E. Cemetery
LOCATION (City, town, or county) (State) Pocomoke, Md.

DATE REC'D BY LOCAL REGISTRAR 10-1-54
REGISTRAR'S SIGNATURE Mary W. Holloway
24. FUNERAL DIRECTOR Dennis & Watson, Pocomoke, Md. ADDRESS
Per M.W.H.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08873 08900

CERTIFICATE OF DEATH

Reg. Dist. No. 332

1. PLACE OF DEATH:
COUNTY Wicomico MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury
LENGTH OF STAY (in this place) Most of life
HOSPITAL OR INSTITUTION OR STREET ADDRESS 340 Delaware Ave.

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland COUNTY Wicomico
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury
STREET ADDRESS (If rural give location) 340 Delaware Ave.

3. NAME OF DECEASED: (Type or Print) (First) Fannie (Middle) (Last) Wallace

4. DATE OF DEATH: (Month) 9 - (Day) 29 (Year) 1954

5. SEX: Female

6. COLOR OR RACE: A.A.

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married

8. DATE OF BIRTH: 7-4-1891

9. AGE last birthday: 63 yrs. IF UNDER 1 YEAR: Months 7 Days 4 IF UNDER 24 HRS.: Hours Min.

10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired): Domestic

10b. KIND OF BUSINESS OR INDUSTRY: Private Family

11. BIRTHPLACE (State or foreign country): Ruckersville, Green Co. Va.

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: William Taylor

14. MOTHER'S MAIDEN NAME: Mary ____ Taylor

15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No (If Yes, give war or dates of service) No

16. SOCIAL SECURITY No.: 214-32-2049

17. INFORMANT & ADDRESS: Dallas Wallace, 340 Del. Ave. Salisbury, Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

16 X

Immediate cause (a) Bronchogenic Carcinoma of Left lung.

DUE TO

Antecedent causes(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. (b)

DUE TO

(c)

Interval Between Onset And Death

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify)

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURED While at Work ☐ Not While At Work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 7/15/54, 19....., to 9/29/54 19....., that I last saw the deceased alive on 9/29/54 19....., and that death occurred at ....., from the causes and on the date stated above.

SIGNATURE Carried Hearn (Degree or title) MD ADDRESS 113 W Church St DATE SIGNED 10/2/54.

23. BURIAL, CREMATION, REMOVAL (Specify) Burial

DATE THEREOF 10-3-'54

NAME OF CEMETERY OR CREMATORY Ruckersville Cemetery

LOCATION (City, town, or county) (State) Ruckersville, Green Co., Va.

DATE REC'D BY LOCAL REGISTRAR 10-2-54

REGISTRAR'S SIGNATURE Mary W. Holloway

24. FUNERAL DIRECTOR Mary A. Stewart, 324 E. Church St., Salisbury, Md. ADDRESS

STEWART FUNERAL HOME

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 08901

08874

CERTIFICATE OF DEATH

Reg. Dist. No. 332

1. PLACE OF DEATH: Wicomico
COUNTY Wicomico MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Salisbury
LENGTH OF STAY (in this place) 14 mos.
HOSPITAL OR INSTITUTION OR STREET ADDRESS Deers Head State Hospital Deerhead Hosp. 70

2. USUAL RESIDENCE (HOME) OF DECEASED: Wicomico
STATE Maryland COUNTY Wicomico
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN ~~XXXXXXXXXXXX~~ Siloam X
STREET ADDRESS (If rural, give location) ~~R.D.~~ # 2 Eden

3. NAME OF DECEASED: (Type or Print) (First) Beacham (Middle) (Beaucham) (Last) White
4. DATE OF DEATH: (Month) 9 (Day) 22 (Year) 1954

5. SEX: M
6. COLOR OR RACE: W
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): M.
8. DATE OF BIRTH: 7-11-1876
9. AGE last birthday: ~~XXX~~ 78 yrs. IF UNDER 1 YEAR Months 2 Days 11 IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired Farmer
10b. KIND OF BUSINESS OR INDUSTRY: On Farm
11. BIRTHPLACE (State or foreign country): Siloam, Maryland
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Joe C White (Joseph White)
14. MOTHER'S ~~MAIDEN~~ NAME: Wilmania Seabrease ~~XXXXXXXX~~

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) Unk (If Yes, give war or dates of service)
16. SOCIAL SECURITY NO.:
17. INFORMANT & ADDRESS: Mrs. Maggie White (Wife) R.D.# 2 Eden,

18. MEDICAL CERTIFICATION Siloam, Maryland

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH: 151X

		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Generalized carcinomatosis	2 months
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating underlying cause last	DUE TO (b) Carcinoma of Stomach	?
	DUE TO (c)	

II. OTHER SIGNIFICANT CONDITIONS: Conditions contributing to the death but not related to the disease or condition causing death. arteriosclerotic Heart disease ?

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE (Specify)
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) M.
INJURY OCCURRED While at work ☐ Not while at work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 7-30, 1953 to 9-22, 1954, that I last saw the deceased alive on 9-22, 1954 and that death occurred at 8:30 P m., from the causes and on the date stated above.

SIGNATURE B. Gore (DEGREE OR TITLE) MD ADDRESS Deerhead St. Hosp. DATE SIGNED 9-22-54

23. BURIAL, CREMATION REMOVAL (Specify): Burial
DATE THEREOF Sept. 25, 1954
NAME OF CEMETERY OR CREMATORY Siloam Cemetery
LOCATION (City, town, or county) (State) Siloam, Maryland

DATE REC'D BY LOCAL REG. 9-25-54
REGISTRAR'S SIGNATURE Mary W. Holloway
24. FUNERAL DIRECTOR HOLLOWAY & COMPANY SALISBURY ADDRESS MARYLAND

Walter R. Holloway

VS. A15 8-51

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
SEP 28 1954
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08875

08902

CERTIFICATE OF DEATH

Reg. Dist. No. 332

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH: COUNTY Wicomico; MARYLAND Md.; CITY (If outside corporate limits, write RURAL) OR TOWN Salisbury / Md; LENGTH OF STAY (in this place); HOSPITAL OR INSTITUTION OR STREET ADDRESS +

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Md.; COUNTY Wicomico; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Dolis +; STREET ADDRESS (If rural give location) 616 Isabelle St

3. NAME OF DECEASED: (Type or Print) (First) Albert (Middle) (Last) Williams

4. DATE OF DEATH: (Month) Sept (Day) 8. (Year) 1954

5. SEX: M

6. COLOR OR RACE: C

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Widow

8. DATE OF BIRTH: June 12 1884

9. AGE last birthday: 70 yrs. IF UNDER 1 YEAR: Months / Days; IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION. Give kind of work done during most of working life, even if retired: Laborer

10b. KIND OF BUSINESS OR INDUSTRY: none

11. BIRTHPLACE (State or foreign country): Delmar Md

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Eaton Williams

14. MOTHER'S MAIDEN NAME: Rosie Parker.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)

16. SOCIAL SECURITY NO.: ✓

17. INFORMANT & ADDRESS: Jasper Williams

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Convulsions — Interval Between Onset And Death: Day

DUE TO

Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. (b) Nephritis — Unk.

DUE TO

(c) Hypertensive Heart Disease — 2 yrs.

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

4142X

19a. DATE OF OPERATION: —

19b. MAJOR FINDINGS OF OPERATION —

20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY

(CITY OR TOWN) Salisbury (COUNTY) Wicomico (STATE) Md

TIME (Month) (Day) (Year) (Hour) OF INJURY — m.

INJURY OCCURED While at Work ☐ Not While At Work ☐

HOW DID INJURY OCCUR? —

22. I hereby certify that I attended the deceased from Aug 11 1954 to Sept 8 1954, that I last saw the deceased alive on Sept 6, 1954 and that death occurred at 6 43 Am from the causes and on the date stated above.

SIGNATURE (Degree or title) B. Herbert Sembly MD ADDRESS Salisbury Md DATE SIGNED 9/9/54

23. BURIAL, CREMATION, REMOVAL (Specify) Buried. DATE THEREOF Sept. 11. 1954 NAME OF CEMETERY OR CREMATORY Union Cem LOCATION (City, town, or county) Delmar (State) Md.

DATE REC'D BY LOCAL REGISTRAR 9-10-54 REGISTRAR'S SIGNATURE Maylie Holloway

24. FUNERAL DIRECTOR Booker & Veach ADDRESS

RECEIVED
SEP 14 1954
BUREAU V. S.